Governing drug use among young people: Crime, harm and contemporary drug use practices

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Abstract

Since the nineteenth century, drug use has been variously understood as a problem of crime, social problems and addiction. The drug 'problem' has subsequently been the focus of an immense body of research, much of which is founded on assumptions of inevitable harm and is directed towards preventing drug use or developing solutions to the problem. This problematisation of drugs has generated a range of law enforcement responses, drug treatment technologies and rehabilitative programs intended to prevent drug related harm and resituate drug users in the realm of functional citizenship. Yet in recent years, interest groups have been vocal in their concerns that efforts to address drug related 'harm' have actually exacerbated harm. While this thesis does not propose alternatives for policy or practice, it does seek to analyse the knowledges, truths and rationalities that have made drugs a problem and to understand the effects of this problematisation.

By taking an empirical, critical approach to the problem of drugs, this research aims, firstly, to understand how historically contingent knowledges of problematic drug use have shaped the government of drugs and drug users in Australia. Secondly, the research aims to understand how notions of the drug problem, framed through discourses, policies and practices of harm reduction, influence how young people use drugs, what they believe about their drug use and how they respond to it.

Using Foucault's conceptual framework of governmentality, this thesis seeks to understand young people's drug use as 'practices of the self'. From this perspective, drug use practices are formed through an interaction of the government of illicit drugs and the drug user's own subjectivity. To understand this relationship, qualitative interviews were conducted with police, drug researchers, legal and medical professionals, drug service providers and young people who used drugs. The findings of the research allow for a reconceptualisation of the drug problem in drug policy and research. This opens up possibilities for new directions in drug research and a redefinition of drug related harm, which takes into account the relationship between discourses, policies and practices, and the formation of a drug user self.

Contents

List of Tables

List of Abbreviations

ABS	Australian Bureau of Statistics
AMA	Australian Medical Association
ATS	Amphetamine Type Stimulant
COAG	Council of Australian Governments
DEA	Drug Enforcement Administration
DUMA	Drug Use Monitoring Program
INCB	International Narcotics Control Board
MDMA	3,4 methylenedioxy-methamphetamine
MMT	Methadone Maintenance Treatment
MSIC	Medically Supervised Injecting Centre
NA	Narcotics Anonymous
NSP	Needle Syringe Program
NTA	Narcotics Treatment Administration
OD	Overdose
SAODAP	Special Action Office for Drug Abuse Prevention
SSOT	Society for the Suppression of Opium Trade
TGA	Therapeutic Goods Association
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Statement of Original Authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature: 

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CHAPTER ONE: INTRODUCTION

This introductory chapter locates the thesis within historical, social, political and economic contexts of drug policies and practices, and the various representations of the problem drug user. This chapter outlines the historical background of the research and briefly discusses harm reduction, drug related crime and the polarisation of drug users as central themes for the research. The chapter also sets out the research objectives, highlights key elements of Foucault's governmentality framework and its relevance to the research, and states the research aims and questions. Finally, this chapter outlines the thesis structure, with a brief summary of the chapters.

Background to the Thesis

Since the nineteenth century, drug users have been variously understood as socially deviant, pathological, weak-willed, diseased, or victims of dysfunctional social, environmental or familial circumstances. My thesis seeks to illustrate the historical contingency of these representations and to explore the drug user as a subject of external authority and self-governance. In this investigation, the research traces the historical, political and social changes that occurred from the nineteenth century to the twenty-first century, which shaped contemporary understandings of the problematic, drug-using subject of legal and medical governance. This thesis does not seek to critique or confirm the realities of drug use, engage in debates regarding drug related harm, or prescribe alternative policies or practices for governing drug use. Rather, the research makes an original contribution to knowledge by moving beyond questions of why people use drugs, or how the problem can be addressed, to understanding how particular drugs have come to be defined as a problem, and how this problematisation has shaped contemporary responses to drug use and drug use practices. This research rejects the idea of a pre-given problem of drugs and drug use, and explores the rationalities, policies, practices, and social and economic shifts, which have culminated in the 'drug problem'.

The focus of the research is how young people's illicit drug use is governed in contemporary Australian society and how the governance of drugs, through law, public health and medicine, intersects with self-governance to shape young people's

drug use practices. The term ‘illicit’ drug use is used in preference to ‘illegal’ drug use, as it encompasses illegal drug use and also the use of legal substances that are used in ways deemed illicit, such as the use of pharmaceutical substances in ways other than those prescribed. However, these terms are used interchangeably throughout the thesis. The research is about young people because they are more likely than older groups to use illicit drugs, and their drug use is generally more diverse than drug use among older drug users (Australian Institute of Health and Welfare, 2011). This diversity allows for a richer analysis of the ways in which drug use is governed and how drug users respond to various forms of governance. The research is concerned with the drug problem in Australia, however, throughout the nineteenth and twentieth centuries, the influences of Britain and the United States were fundamental to shaping Australia’s drug problem (Manderson 1987) and, therefore, are an integral part of the historical analysis in this thesis.

Themes for the Research

Reducing harm

Medical and public health responses to illicit drug use are premised on the assumption that drugs are necessarily harmful and should be addressed through harm reduction measures. The logic of harm reduction policy and practice is that the threat of HIV/AIDS to the community outweighs the threat posed by injecting drug use (Ritter and Cameron 2005, 5). More broadly, harm reduction is concerned with a reduction in individual and community harms, including health, and social and economic harms related to the use of illicit drugs. In Australia, the National Drug Strategy provides a policy framework for the reduction of harmful drug use (Ministerial Council on Drug Strategy 2004). However, the component of supply reduction through law enforcement, within the harm reduction policy framework, has led to criticisms that harm cannot be reduced by criminalising drug users through law enforcement (Miller 2001; O’Malley 1999; Lenton and Single 1998; Wodak and Moore 2002). Harm reduction policy underpins health policy, drug treatment programs, rehabilitation and drug diversion programs, preventative drug education programs, and safe injecting programs. This thesis will illustrate how harm reduction is also a moral obligation of injecting drug users.

Responding to drug related crime

Assumptions of a causal link between drug addiction and crime form the basis of numerous theories, academic and policy literature, and drug research projects (Ball, Shaffer and Nurco 1983; Chandler, Fletcher and Volkow 2009). While there is little doubt of a link between drugs and crime, this link has only existed since a tightening of punitive drug policies during the 1970s and 1980s, which resulted in a focus on socially and economically deprived groups. Further, the linkage is complex and dependent upon a number of factors other than drug use per se (Seddon 2006; Manderson 1993). Nevertheless, drug related crime continues to be a central focus of policy responses to the drug problem (Seddon 2006; Hough 2001). In Australia, the funding and resources committed to drug law enforcement efforts are substantial, yet it has been argued that police drug interventions are largely ineffective in reducing those activities that are deemed to produce individual and community harm, such as injecting drug use, drug dealing and drug offences (Mazerolle et al. 2007).

'Normal' and 'dependent' drug users

In drug policy documents, media, drug research and public discourse drug use and drug users are categorised as either recreational or dependent. This dichotomy tends to be premised on distinctions between individuals who are productive or unproductive and drug use that is perceived as orderly or disorderly. This categorisation of drugs and drug users has been criticised for failing to acknowledge the fluidity of poly drug use and for assuming that such categories are static, rather than historically contingent.

Categorisations of drug users are however, not simply imposed by external discourses and authorities, but are also a complex process of self-definition, by which drug user identity is produced and intertwined with what drug users believe about their drug use and how they react to it (Coomber and Sutton 2006; Davies 1997). From this perspective, drug user identities are contingent on a range of structural and individual circumstances, such as employment, relationships, peer groups and so on, in addition to beliefs about drug use that are formed within social institutions. This thesis does not dispute that the repetitive use of some substances produces a range of adverse effects that interact negatively on an individual's health,

lifestyle and wellbeing. However, the research seeks to investigate how notions of addiction and habitual drug use are constructed as a static, physiological condition and how this condition can become part of a drug user's identity and beliefs about their drug use, founded upon what best serves their purposes and society's definitions of their behaviour (Davies 1997).

The Research

Research aims and questions

The objective of this thesis is to understand the 'problem' of drug use as historically contingent and subjective, rather than a pre-given problem of chemical harm, or social or individual pathology. The thesis seeks, firstly, to explore the technologies that govern drug use and the rationalities that underpin the problematisation of drug use and drug users, and, secondly, to explore how young people form a drug user self through their drug use practices. The following two research questions are concerned with the ways in which young people, in different social contexts, self-govern and form their drug use practices at the interplay of the governance of drugs and their own drug user subjectivities:

1. What are the technologies that govern drug use, and how are these made possible through contemporary knowledge, truths and political rationalities?

2. How do young people form a drug user self through an interaction of authoritative governance and their own drug use practices?

Governmentality framework

Michel Foucault's concept of governmentality is concerned with the interaction between external governing authorities, including influences, such as the family or the church, and the government of oneself. Governmentality is concerned with the problems of government and how to govern to ensure the wellbeing of the population. Therefore, it offers a helpful framework for analysing how drugs and drug users are problematised and controlled, because it encourages open-ended accounts of the practices of government in specific fields (Garland 1997).

Problematisation is an important element of governmentality, as it enables an understanding of the interaction between power and government. It is related to the exercise of power and is consistent with the objectives of authorities, which are in accordance with governmental rationalities (Rose and Miller 1992). The rationalities of government are systems of thinking about government in terms of practices, such as the activities of government, who can govern and who is governed (Gordon 1991, p. 3). These are supported by governmental technologies that are designed to observe, regulate, monitor and shape the behaviour of individuals within social and economic institutions to facilitate governmental ambitions (Gordon 1991; Rose and Miller 1992).

Governmentality as a method

Governmentality encompasses three historical frameworks — liberalism, welfarism and neo-liberalism. These frameworks make governmentality suitable for historical, empirical work, as they provide an effective method for capturing ruptures in policies, knowledge, techniques and practices that take place at the intersection of social, political and technological shifts. Foucault did not propose a universal truth, a continuous progression of history, or fixed subjects who were attached to specific identities. Rather, he was interested in disrupting the status quo in order to understand the nuances, complexities, historical mutations and contingencies that form social life in the present. Against the historical background of this thesis, Foucault's approach allows for an analysis of the technologies that govern drug use, and an analysis of how drug use practices and subjectivities are formed through various technologies of governance.

Research interviews

In order to address the research aims and questions, data was collected through qualitative interviews. Fifteen drug service providers and other professionals working in areas of law, policing, drug education, medical care and health services were interviewed about their roles in governing drug use and drug users, and their views on drug policies, practices and interventions. Twenty-nine young people, comprising two groups who clearly defined themselves as 'recreational' drug users and 'addicts', were interviewed for the research. The recreational users comprised a

sample of 20 university students and full-time workers, while the self-defined addicts constituted nine unemployed, homeless young people who regularly accessed drug services. Not only did these groups conform to specific sociodemographic characteristics, they also enacted particular drug use practices that were tied to their identities and beliefs about themselves as drug users.

Structure of the Thesis

Chapter Two of this thesis explores the social and cultural contexts of drug use from the nineteenth century to the 1960s. This is an investigation of the social, economic and political relationships and contingencies that have shaped contemporary drug use as a problem for societies. A historical analysis of changes that occurred during the nineteenth century provides a background for understanding changes in drug regulation, legislation, policy and practices that occurred during the twentieth century. The purpose of this chapter is not to present a genealogy of drug use, but to provide historical background to the drug 'problem', which allows for a trajectory of nineteenth and twentieth century rationalities that gave way to the development of contemporary technologies for governing the drug problem.

Chapter Three is a review of historical and contemporary sociological, criminological and medical literature on illicit drug use, drug policies and drug practices. Beginning from the 1960s, the chapter discusses drug subcultures, and investigates developments in public health policy and law from the 1960s onwards, and the growth in young people's drug use and drug cultures that accompanied these developments. The chapter also reviews the literature on various types of drug use among young people, and how users are constructed as unproblematic and 'recreational' or problematic 'addicts' in need of governance. The chapter discusses the interaction of medical, public health and criminal justice governance in prison rehabilitation processes, extra-judicial programs and drug diversion programs. These programs involve various invasive technologies, such as urine testing, that are underpinned by rationalities of harm reduction. To enable an understanding of their historical and political contingency the chapter links these technologies to medico-moral and judicial developments described in Chapter Two.

Chapter Four describes the methodology for the research and provides an overview of Michel Foucault's concept of governmentality as a framework for locating the history of the 'drug problem' within the 'biopolitical age'. It explains the relevance of Foucault's method to the research and the advantages of the approaches taken in the research. Chapter Four also discusses the data collection process including participants, sampling, interviews and coding for the thematic analysis. Governmentality provides a way of understanding how drug use has been problematised and responded to as a biopolitical problem and as an issue for neo-liberal governance. Problematisations are central to my research as they enable an understanding of how power and government interact to make particular problems salient, and justify, through political rationalities, how problems are to be governed. Problematisations are aligned with the rationalities of government in terms of who should govern, who should be governed and how. Governmentality also allows for an understanding of how individuals self-govern in an alliance between political rationality, experts and the individual, where the objectives of government and the individual are the same. It is through this interaction that the self is formed.

Chapter Five analyses data from interviews with15 drug service providers and other professionals whose specialisations are in the fields of public health, law and law enforcement, drug education, psychological and counselling support, and research. This analysis seeks to understand the historical, social and political contingencies that have made drugs a problem in contemporary societies. The chapter addresses the first of the research questions by exploring the technologies that govern drug use and drug users, and how these forms of governance are shaped within relationships between knowledge, truth and political rationalities. Foucault's concept of governmentality in this chapter allows for a conceptualisation of the 'drug problem' and contemporary responses to the problem, as an interaction between power, knowledge and political rationalities. From this perspective, objects of governance such as clinics, treatment centres and drug rehabilitation programs have been formed through historically contingent problematisations rather than simply as a response to harmful drug use.

Chapter Six analyses the data from interviews with drug users. This chapter answers the second research question by exploring how drug users form a drug user self

through an interaction of authoritative governance and their own drug use practices. The purpose of the chapter is to understand how the drug user self is produced through forms of authority and drug use practices. Foucault's work on truth, knowledge, power and the constitution of the self provides a conceptual framework for understanding how drug users form truths about themselves through scientific knowledge of drug use and through the practices of social institutions such as education systems, clinics or the criminal justice system.

Chapter Seven summarises the research, setting out the limitations of the methodology and the research, and providing a discussion of how the drug problem could be reconceptualised as a constantly changing effect of government, rather than a pre-given inherent characteristic of the drug user's physiology, or social or environmental pathology.

Conclusion

This thesis finds that technologies of government that are directed at managing the population through health, and law and order, are not simply coercive responses to illicit drug use, but encourage drug users to self-govern their drug use in line with the objectives of government. The self is formed through the interaction of technologies for governing the drug problem, and the drug users' own drug use practices. It is argued that understanding the formation of a drug user self is important because it reveals the contingent, shifting and changing subjectification that is at work in the construction of 'truths' such as 'recreational' drug users and 'addicts'. These truths produce knowledge about drug users, and shape policy and practice, with some very real implications for the lived experiences of drug users.

CHAPTER TWO: A HISTORY OF THE DRUG PROBLEM

The aim of this chapter is to trace the social and cultural contexts of drug use from the nineteenth century to the 1970s. The chapter explores the networks of social, economic and political relationships and contingencies that have shaped contemporary drug use as a problem for societies. This chapter begins from the premise that drug problems do not exist in themselves, but rather have emerged alongside complex debates through which drugs have been deemed to be dangerous substances in need of regulation. By making some of these historical debates visible, the chapter seeks to show how medicine, law, public health and criminology have contributed to present understandings of drugs and drug users.

This chapter focuses primarily on opiate based substances and, to a lesser degree, cocaine and cannabis. My emphasis on opium and heroin does not reflect the focus of the current research, nor does it suggest a hierarchy of drug dangerousness or the prevalence of drug use in contemporary society. Rather, these substances have emerged as key concerns for Western societies since the nineteenth century and their production and use have played a significant part in shaping responses to drug use. The focus of the research is Australia, however a history of the drug 'problem' is not an autonomous history, nor has it occurred in isolation but rather, through a complex alliance between the United States, Britain and Australia. Therefore, the chapter attempts to capture the complexity and contingencies of political relationships between the three countries that made drugs a problem. This chapter is divided into two parts: the nineteenth century and the twentieth century. A historical analysis of changes that occurred during the nineteenth century provide a background for understanding changes in drug regulation, legislation, policy and practices that occurred during the twentieth century. The chapter concludes with the changes that occurred following President Nixon's launch of the war on drugs.

Nineteenth Century Opium Regulation

An acceptable practice to a public health problem

During the nineteenth century in Britain, Australia and the United States, opium was mostly consumed through pharmaceutical preparations intended for a wide range of ailments including sleeplessness, acute pain, infant teething, stomach complaints and menstrual pain (Berridge and Edwards 1987; Manderson 1993). In Britain, the most commonly used drugs for pharmacological and therapeutic purposes were opium, cocaine and cannabis. While cocaine was valued for its anaesthetic properties, the medical popularity of cannabis was due to its analgesic and sedative effects. Opium however, which had been in use in Western Europe since at least the sixteenth century, was the most important drug in pharmacology at the time, and was highly valued for its pain relieving and euphoric properties (Berridge and Edwards 1987). Opium was not regarded as dangerous or threatening and its habitual use gained little public attention before the publication of Thomas De Quincey's *Confessions of an English Opium-Eater* in 1822, describing the 'pains' of ceasing opium use (Berridge and Edwards 1987; Hickman 2004). Nevertheless, opium eating remained an acceptable practice and could be bought in any English grocer's or druggist's shop up to the 1850s (Berridge and Edwards 1987, p. xxvii). The users of opium were mostly professionals and older women and few young people took the drug in any extensive quantity (Berridge and Edwards 1987). In Australia, opium was the most widely used drug up until the 1880s, and according to Cannon (1975) opium preparations were carried by nearly every Australian gold digger, squatter and itinerant shearer (p. 133).

Insurance and the public health movement

Although there was a general public concern about the health dangers of opium during the nineteenth century in Britain, there was a range of factors that contributed to opium use being defined as a problem. Opium was first viewed as a problem in Britain in 1828 after the death of the Earl of Mar when his insurance company learned of his excessive laudanum use for the previous 30 years. His insurance company refused to pay out on his policy, and when the case went before the Scottish courts it was found that the Earl had chosen to make his life unhealthy, and

therefore was responsible for his death (Berridge 1979). Seddon (2010) argues that the case of the Earl roots the early problematisation of opium in liberal notions of autonomy and personal responsibility[1]. Life insurance companies became pioneers in epidemiology and public health due to their corporate interests in generating statistical data of mortality and disease to calculate insurance premiums (Seddon 2010). With their fears that opium affected health and shortened lives, they were also an important part of the emergence of the public health movement that expressed concerns about the easy availability and effects of opium (Berridge and Edwards 1987, pp. 75 & 85). The public health movement that emerged in Britain during the 1840s, under the reformer Edwin Chadwick, was largely driven by fear of the potential for disease to impact on worker productivity or cause premature deaths among male breadwinners. From the perspective of public health reformers, using government money to improve public health would save money in the long-term by saving on providing poor relief to widows and orphans (Lupton 1995; Hamlin 1998). Chadwick was charged with documenting the extent of insanitary conditions and disease, and exploring remedies. The resulting *Report on the Sanitary Conditions of the Labouring Population* (1842) discussed insanitary conditions resulting from social as well as biological disease. Psychological degradation was said to lead desperate people to alcohol or even revolution (Lupton 1995; Hamlin 1998; Berridge and Edwards 1987); the report also mentioned the problem of opium use (Berridge and Edwards 1987, p. 77).

Terms such as 'public health' and 'social hygiene' came to replace the idea of medical 'policing'[2] and there was an increasing use of statistical techniques to measure population estimates, longevity, mortality and procreation rates. This was fundamental to the development of the public health movement as a scientific and professional discipline encompassing preventative medicine and epidemiology

[1] At the same time however, there was recognition of the inherently dangerous properties of opium due primarily to a large number of deaths resulting from opium poisoning. Nevertheless, the fatalities were not an inevitable consequence of the drug, nor were they disproportionately high relative to the frequency of use; rather they were the outcome of self medication and a lack of accessible medical care (Berridge and Edwards, 1987: 77). Case histories of opium poisonings were well documented in medical journals and opium became established in the 1850s and 1860s as a public health problem requiring the professional control of medical experts (Berridge and Edwards, 1987: 77).

[2] The concept of 'medical police' first emerged in Germany and later spread to other parts of Europe and the United States. Policing in this sense was concerned with the regulation of functions such as hygiene, water supply and maintaining street cleanliness (Lupton, 1995: 24).

(Lupton 1995, pp. 24-25). Good health became a measure of civilised cultural values of self-restraint and self-control while 'unhealthy' was a representation of irresponsibility, lack of hygiene and inferiority (Elias 1983; 1994). In the United States, Britain and Australia, these unhealthy traits were typically associated with immigrants, the poor and working classes, and racial and social inferiority (Berridge and Edwards 1987; Manderson 1993). With growing perceptions of the working class as a social category characterised by excessive drinking, undisciplined children, licentious sexual behaviour and poor personal hygiene, there were calls for regulation and 'cleaning up' of the underprivileged social groups. Hygiene was seen as a process for civilising, disciplining and instilling morals, education and good conduct into the poorer classes (Lupton 1995, p. 35).

The regulation of opium

A problem of class

Within the public health framework opium use was not simply a problem of the drug, but was also a problem of who was using the drug and how. Kendall and Wickham's (1992) account of the health of cities and the social body illustrates how the problem of health in nineteenth century England was directly related to class (p. 11). The notion of the 'dangerous' classes came to be inherently associated with the unhealthy conditions of existence of the poorer classes. At the same time, statistical calculations mapping patterns of disease and crime made causal links between poor health, crime and the working classes (Kendall and Wickham 1992, p. 14). Sites of dangerousness became closely related to poor health and crime in industrial cities where the working classes lived in overcrowded, unhealthy conditions (Kendall and Wickham 1992, pp. 11-12). Similar concerns existed in colonial Australia due to a growing sprawl of immigrants in Sydney slums during the mid to late nineteenth century. The population growth stimulated by the gold rushes had resulted in overcrowded living conditions, lack of sewerage and drainage, poor health among residents, and high rates of disease, crime and mortality (Ramsland 1986; Cannon 1976). With lower than average life expectancy among convicts, emigrants and gold-seekers, and enormous wastage of urban population from diseases, there was a focus on public health measures to increase longevity and improve the health of the population (Cannon 1976, pp. 128-129). At the same time, problems of poor health,

prostitution and child crime were linked to the inherent characteristics and 'corrupting influences' of the poorer classes (Carrington and Pereira 2009; Ramsland 1986).

It was in this social context that middle-class opium use was considered much more acceptable than its use within the working classes. Some of the main concerns expressed in public health debates about the dangerousness of working class opium use included 'infant doping' and working class 'stimulant' use of opium (Berridge and Edwards 1987, p. 97). Public health concerns about the dosing of babies with soothing syrups containing opium were underpinned by class interests and an ideology of a more acceptable popular culture. Campaigns against practices of child doping were focused on criticisms of working-class mothers with little attention paid to the same practice by medical professions and the wealthier classes (Berridge and Edwards 1987). In reality, pharmacists regularly dispensed opium-based remedies for children and infants and many doctors continued to prescribe opiates for children of all classes (Berridge and Edwards 1987, p. 103). The belief that the working classes were using excessive amounts of opium for 'non-medical' stimulant purposes reinforced the public health perception of the opium problem as a class problem (Berridge and Edwards 1987, p. 106). It was this focus on the way opium was being used by the working class, and on the unregulated supply of opiates that led to the first restrictions on the availability of the drug in the *1868 Pharmacy Act*. It was argued that the drug should be strictly managed by professional men however regulation remained contentious due to conflicting professional interests between doctors who were in favour of severe restrictions, and pharmacists who fought to limit control of opiate sales (Berridge and Edwards 1987, pp. 117-118).

The race problem

At the same time, fears of the spread of opium smoking among lower-class Chinese in London dock areas was of great concern and encouraged restrictive attitudes (Berridge and Edwards 1987, p. xxviii). These concerns were to some extent

influenced by the Temperance Movement[3] which provided support for alcohol prohibition and intervention, and linked patterns of alcohol consumption among the lower classes to an increase in opium consumption (Berridge and Edwards 1987, pp. 107-108). Similar to the situation in Britain, the regulation of opium in Australia during the nineteenth century was associated with opium smoking in Chinese communities, where it was smoked as a recreational activity (Manderson 1993; Brown et al. 2001). The 'problem' of Chinese immigrants in Australia was, in part, related to colonial insecurities of dispossession due to the influx of new Chinese immigrants attracted to the gold rushes of the mid nineteenth century. The Chinese were perceived as invaders who threatened not only Australia's gold reserves, but also the European race (Day 1988). In 1901 these anxieties about cultural homogeneity culminated in the introduction of the White Australia Policy (Hogg and Carrington 2006; 2003). Nevertheless, early Australian opium legislation was underpinned, not only by fears of race, but also of sexual morality and an ideology of physical health and purity for the future development of Australia. In particular, there were fears that Chinese men were coercing white women and girls into smoking opium to sexually seduce them[4] (Manderson 1993, p. 25). There were also fears that Chinese men were using opium to seduce Aboriginal women (Manderson 1999); these concerns in part, gave impetus to the *Opium Act 1895* and the *Aboriginal Protection and Restriction of the Sale of Opium Act 1897*, prohibiting the sale of opium to Aborigines in Queensland[5].

In the United States, a national drug problem was declared following concerns of increased narcotic use at the end of the Civil War era. This was a consequence of civil war hospitals using opium and morphine[6] and veterans returning home addicted to narcotics (Bonnie and Whitebread 1970, p. 983). There were also concerns that

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[3]Temperance was a mass movement of the middle class and was powerful in its influence on social reform, not only in its anti-alcohol campaigning but also in its close alliance with anti-slavery and women's rights movements (Levine and Reinarman 1991, p. 462).

[4] The theme of female sexuality and seduction by drug dealing 'men of colour' was also evident in early twentieth century British discourse. The death of the West End's 'leading lady' Billie Carlton in 1915, after she used cocaine, resulted in the trial of the West End drug underground figure Brilliant Chang who allegedly supplied her the drug (Kohn 1992; Seddon 2008). Carlton's death sparked a campaign of race-based thinking about drugs for much of the twentieth century (Seddon 2008).

[5] There were also concerns about pastoral employers paying Aborigines their wages in opium (Hagan, Castle and Clothier 1998).

[6] Morphine was used in the early nineteenth century as a cure for excessive alcohol use, and later in the mid 1860s as a cure for opium eating (Berridge and Edwards 1987).

Civil War veterans were spreading addiction by recruiting other users (Musto 1999). Additionally, the drug using population in the United States was shifting from predominantly middle and upper class white women, whose medical prescriptions had created a narcotics habit, to lower class urban men with interests in criminal activities; narcotics use subsequently became associated with deviance and social disorder (Hickman 2004, p. 1270). In 1909 smoking opium was suddenly prohibited in the United States, partially due to its association with the Chinese who were by this time almost totally excluded from immigration into America (Musto 1999). From the nineteenth century, addicts were identified with feared foreign groups and minorities, particularly Chinese and Negro groups, who were objects of severe social and legal constraint. There were fears that the Chinese would undermine American society, and by 1900 in the south, there were fears that Negroes under the influence of cocaine might attack white society. These racially motivated fears coexisted with the peak of lynchings, legal segregations and disenfranchisement of black people (Musto 1999). At the time cocaine was used in the United States as a general tonic for sinusitis and hay fever and as a cure for opium, morphine and alcohol addiction (Musto 1999). The historical relationship between public health, hygiene, and the unregulated drug use that manifested in the nineteenth century as problems of race, class and the security of the nation, illustrates that drug regulation has not simply been about problems of health or addiction, but rather, a complex interplay of social factors. The linkages between these historical accounts, and the ways in which we think about and govern drugs in contemporary society will be explored further in Chapter Five.

Medicine, morals and regulation

Opium: a lucrative trade

By the end of the nineteenth century in Britain and Australia, the purchase of opium products, derivatives and opium based patent medicines was restricted to pharmacists' shops. Regular opium users were no longer habitual users, but were classified as sick, diseased or deviant individuals requiring professional treatment (Berridge and Edwards 1987; Manderson 1993). The racial sentiments of anti-opium propaganda and the impact of the opium wars in China contributed to hostile perceptions of opium use in England and resulted in parliamentary opposition to the

drug (Berridge and Edwards 1987 pp. 173-174). Since the late eighteenth century Indian opium had been shipped by the British to China via the East India Company. When in 1839 the British refused, at China's request, to cease the trade the first opium war erupted between Britain and China. The war resulted in the Treaty of Nanjing, which saw Britain acquire five Chinese ports for trade as well as the colony of Hong Kong. The opium trade in China expanded significantly and following a second opium war from 1856 to 1860, Britain gained control of the Kowloon Peninsula (Lintner 2002, pp. 26-27). While Britain had some concerns about the moral implications of their commerce, there were considerable tax revenue benefits for British India, with opium producing more than one-fifth of government revenue in the empire (Lintner 2002, p. 24).

Moral opposition to Britain's involvement in the opium trade was growing, particularly among Temperance campaigners who condemned the trade as a system of revenue (Berridge and Edwards 1987, p. 177). In 1874 the most prominent organisation in the anti-opium movement, the Society for the Suppression of the Opium Trade (SSOT), was founded by a group of Quaker anti-opium campaigners (Harding 1986; Berridge and Edwards 1987). As strong moral campaigners committed to using political practices to change what they perceived as social wrongs, the Society campaigned for the next 30 years against what they regarded as exploitative practices endorsed by British colonial policies. The Society's main moral objections were articulated through religious discourse condemning the evils of non-medical, gratuitous consumption of opium, enforced by the British. The campaigners succeeded in persuading British public opinion that non-medical consumption of opium was evil in a religious sense (Harding 1986, p. 80). With at least one third of the population of China said to be addicted to opium and a belief that addiction was crippling the country, there were other calls by foreign missionaries and educated Chinese to cease the trade (Berridge and Edwards 1987). In 1906, with a newly elected British Liberal party including among its candidates members of the anti-opium movement, Britain introduced a resolution to bring the opium trade to a close (Bull 2008 p.59). In 1909, the first international conference of the International Opium Commission, initiated by the United States (Bewley-Taylor 1999), was convened at Shanghai by the United Nations to discuss the British opium trade with China (United Nations Office on Drugs and Crime 2009). Finally, at a

conference at The Hague in 1911 attended by 46 countries, Britain agreed to abolish all importation of Indian opium by 1917 (Lintner 2002, pp. 29-30).

Harding (1986) argues that the campaigning of the SSOT was based on a 'moral-pathological' model of opiate addiction as a specific condition (p. 81). The model was premised upon the Quaker rationale of the SSOT's founders, at the core of which was recognition of one's material and spiritual responsibilities to avoid luxuries, undue expenditure and self-indulgence. There was also an obligation to exercise moderation, industriousness and simplicity. SSOT founders perceived addiction as a symptom of a pathological impairment of normal moral functioning that resulted in the addict irresponsibly denying his own morality (Harding 1986, p. 82). The puritan construction of the opium habit as an 'evil' by the SSOT was a new concept and represented an important shift from understanding inebriety as over-enjoyment of a substance such as alcohol or opium, to a paradigm of addiction that related to an individualised condition (Levine 1978). Up until the third quarter of the nineteenth century the medical analysis of addiction had been solely concerned with opium's physiological and pharmacological effects on the body, however the moral state of the user had been of little or no consequence (Harding 1986, p. 83). Following the formation of the SSOT the 'habit' as a symptom of a pathological disease of the will gained popularity, and by the last decade of the nineteenth century medical professionals were linking the effects of the opium habit to a deterioration of moral character (Harding 1986, pp. 82-83). According to Berridge and Edwards (1987) the medical profession's perceptions of the opium problem were the product of broader structural changes of the nineteenth century that produced a rapidly expanding middle class, of which doctors were an integral part (p. 76). Variations of the religious moral-pathological concept of addiction in contemporary understandings of recreational and habitual drug use and drug users will be explored in Chapter Six. Threads of the Quaker ideology will also be explored in Chapter Six with regard to contemporary forms of drug rehabilitation.

Inebriety[7] came to be associated not only with alcohol, but also with opium use, and reports in *The Lancet* highlighted the degeneration of the moral character of the addict, and encouraged moral treatment through steady work (Harding 1986, p. 84). These analyses were a combination of discourses of the 'opium problem' promoted by the Temperance Movement, and those that were rationalised on the basis that they constituted medical science. The Temperance Movement, with a strong organisational association with the medical profession, was influential in shaping medical understandings of opium use within the inebriety paradigm of the Temperance Movement[8]. Temperance discourses held that inebriety was the major cause of nearly all social problems such as unemployment, poverty, business failure, slums, insanity and violence (Levine and Reinarman 1991, p. 462). A person's vulnerability to inebriety could be environmental or constitutional and was said to leave a permanent impression on inebriates' nerves, which was aggravated by repeated administration of the drug. Also concerning was that the trait of inebriety could be passed on as degenerative constitution tendencies that could result in an inebriate's child being an opium addict, or inheriting some other congenital, physical or intellectual impairment (Courtwright 2005, p. 108).

The injecting middle class

With a dominance of middle class medical professionals in the regulation of opium, the focus of the problem shifted from working class use to hypodermic morphine use by a small number of injecting morphine addicts of the 'respectable' classes[9] (Berridge and Edwards 1987, p. xxix). As an important medical 'growth area' in the last decades of the nineteenth century, medical textbooks regularly contained sections on the 'morphia habit' (Berridge and Edwards 1987, p. 152). Morphine had only come into popular use during the 1860s with the emergence of the hypodermic syringe in medical practice (Parssinen and Kerner 1980, p. 276). However, the use of the hypodermic syringe was regarded as a secondary effect of middle class patients

[7] The notion of inebriety theory was premised on three popular medical concepts: neurasthemia or nervous weakness, diathesis or constitutional predisposition to chronic disease, and degeneration or transmission of morbid deviations across generation (Courtwright 2005).
[8] In medical and social terms alcohol and opium had been grouped under a 'scientific' umbrella concept of 'inebriety' and opium was subsequently viewed along with alcohol, in the context of the Temperance Movement (Berridge and Edwards 1987, p. 154).
[9] Having emerged from the status of the middle class medical profession, addiction was initially concerned with 'respectable' addicts rather than those of the lower classes.

with a fragile nervous system who had trouble coping with the problems of modern life. According to Hickman (2004), the concept of addiction appeared at a time of cultural crisis in modern society. This was a time of identity confusion, and experts were attempting to understand the agency of the human subject within the economic, technological and infrastructural changes of the modern world (p. 1293). There were also concerns that the syringe provided an 'uncivilised' hidden form of pleasure, the consequence of which was a moral decline and an erosion of power (Walmsley 2012, p. 94). A key concern of addiction was the notion of interdependence due to reliance on a chemical and its suppliers, and the effect of this on middle class autonomy. Habitual narcotics use was perceived as a threat to the identity of the independent, autonomous, self-mastery of the middle class, and the middle class narcotics-using subject provided experts and reformers with a concrete example of modernity's hidden menace (Hickman 2004, pp. 1274-1276). The habitual use of morphine was known as morphinism, and the 'morphinomaniac' tended to be either middle class physicians or women whose morphine use had begun through the prescriptions of doctors (Berridge 1979). The higher numbers of middle class addicts was, at the time, attributed to a heavier, more complex brain, which made them more vulnerable to psychological and physiological sensitivities (Berridge and Edwards 1987, p. 158). Women, however, were thought to be more susceptible to morphine use due to the 'weakness' of the female sex, which afflicted them with a nervous disposition (Berridge 1999; Hickman 2004). Fashionable middle class women of Paris were said to make presents of pretty syringes with silver and jewel-set cases to allow for injections at any convenient opportunity (Drury 1899, p. 323).

The middle classes comprised the majority of morphine users and medical diagnoses and treatments of addiction were class based. Attributions of addiction due to physical and nervous exhaustion among 'hard working professionals' such as physicians, lawyers, teachers and clergymen underpinned the establishment of a framework of addiction based on illness and disease. Morphine treatments for the middle classes were generally medical care and expensive treatment in special homes. In contrast, working class habitual opiate users had little choice but to be confined for treatment in an institution or workhouse where they were put to work while undergoing treatment (Berridge and Edwards 1987, pp. 165-170). Working class addicts, considered a minority of addicts, were of little interest to the medical

profession and rarely featured in medical case histories. Theories of disease were rarely applied to working class addicts who tended to be the focus of drug restrictions through the pharmacy acts, rather than medical treatment or intervention (Berridge and Edwards 1987, pp. xxix-xxx).

Diseases of the will

Influenced by scientific positivism, the medical concern with the misuse of drugs during the second half of the nineteenth century was a part of the broader re-classification of a range of conditions, such as homosexuality, insanity, poverty and crime, that became linked to particular types of people (Berridge and Edwards 1987; Royal Commission into the non-medical use of drugs, South Australia 1978). The concept of addiction emphasised an unprecedented distinction between 'legitimate' medical use and 'illegitimate' non-medical use (Berridge and Edwards 1987, p. xxix). At the same time, terminology such as 'drugs', 'addict', 'dependence' and 'abuse' came into common usage by the medical profession and in public discourse (Bull 2008; South Australia, Royal Commission into the non-medical use of drugs 1979; Manderson 1993). As the moral view of addiction became re-formulated in scientific terms there was more of an emphasis on individual psychology, personality and biology, rather than social factors (Berridge and Edwards 1987, p. 153). The addict and their addiction were redefined in terms of their deviation from generally accepted norms of conduct and thought (Berridge and Edwards 1987, pp. 153 & 157). In particular, there was a strong emphasis on predisposition including temperament and hereditary influence. This newly conceived notion of addiction as a biological predisposition and an exclusive condition replaced earlier perceptions of a bad habit potentially affecting anyone, confirming the need for medical intervention (Berridge and Edwards 1987, p. 157).

During the same period however, the medical profession redefined habitual opiate use in terms of a 'disease'[10] (Berridge and Edwards 1987, p. 76). The moral views of addiction that derived from the anti-opium and temperance campaigns became embedded in disease theory (Berridge 1979), allowing for a redefinition of addiction

[10] This formulation of disease theories of addiction was part of a broader development of disease theories in conditions such as typhoid and cholera (Berridge 1999).

as a disease caused by moral weakness and a ‘form of insanity’ (Berridge and Edwards 1987; Valverde 1998). In this shift, moral judgments were given credence by being transferred into medical discourse and practice (Berridge and Edwards 1987, p. 155). Parssinen and Kerner (1980) argue that the characterisation of addiction as disease derived from socio-cultural factors, in particular a ‘culture of medicine’, and the social role, status and political goals of the medical profession during the late nineteenth century. The moral underpinnings of ‘addiction as disease’ represented a paradox in which addiction was to be governed through the domain of medicine, yet simultaneously held the individual personally responsible for their defect. This liberal paradox between the irrational addict to be governed through medical programs, and the rational individual who chose their behaviour, culminated in a diagnosis of addiction as a ‘disease of the will’ (Valverde 1998; Seddon 2010). According to Seddon (2010, p. 57) the dualistic representation of the addict was part of a liberal welfare endeavour to construct ‘social citizens’ capable of taking responsibility for their physical and mental health and that of their family. This will be discussed further in Chapter Five and Chapter Six in the context of neo-liberalism, which has made addicts governable through interventions aimed at identifying and repairing defective characteristics and abnormalities that interfere with their citizenship obligations.

By the late nineteenth century diseases of the will had become a new medical specialisation field (Berridge and Edwards 1987, p. xxvii). According to Berridge and Edwards (1987 pp. xxviii-xxix) the ‘addiction as disease’ paradigm was part of the process of the medical profession legitimising its own status and authority, and the establishment of a ‘professional elite’. Importantly, redefinitions of the addict as a diseased individual situated opiate consumption in the domain of an inevitable personal and physical deterioration. While earlier medical constructions of opiate users had accepted the existence of moderate, stable addicts, the shift to a disease model of addiction encompassed all types of opiate addiction. According to Berridge and Edwards (1987, p. 159) this had the effect of eliminating the possibility of unproblematic drug use, and constructing all users as diseased and problematic, regardless of whether they used in moderation or were ‘uncontrolled addicts’. This has had profound implications for both popular understandings of drugs and drug

users, and national and international drug policy, the legacy of which will be explored further in Chapters Five and Six of this thesis.

By the end of the nineteenth century opium use was set within a new paradigm and an ethic of professional control was firmly in place. A clear distinction between medical and non-medical use of opium was well established with opium being used for a more limited range of medical ailments and conditions (Berridge and Edwards 1987, p. 227). Self-administration of the drug became less prevalent and deaths from the effects of opium were decreasing (Manderson 1993; Berridge and Edwards 1987, pp. 225-226). However, in the last decade of the nineteenth century opium began to be smoked for 'recreational' purposes, along with cannabis and mescal among bohemian, left-wing intelligentsia and artistic society (Berridge and Edwards 1987, p. 205). These 'subcultures' included people like the mystic, occultist and writer Aleister Crowley, and Allan Bennett, a chemist who later became a Buddhist monk, whose interests lay in consciousness-expanding drugs and the recreational use of cocaine. Hashish was a popular drug among the middle and upper classes in Britain at the time and cocaine became the most popular recreational drug up to the 1920s (Berridge 1988, p. 62). In the United States, marijuana and cocaine were popular drugs among jazz musicians, dancers and other entertainers (Bonnie and Whitebread 1970). Concerns about these emerging new drug scenes marked the beginning of recognising drugs as a criminal matter (Berridge 1999).

The Twentieth Century

Policy shifts

Drugs as crime

Drug policies during the twentieth century were underscored by collaboration between the medical profession and governments in Australia, Britain and the United States (Berridge and Edwards 1987; Manderson 1987; Vrecko 2010a; Walmsley 2012). In Britain, legal controls were imposed against opium smoking as an initial attempt to introduce an absolute narcotic policy, however by the First World War

local legal controls against opium smoking had expanded into nationwide controls[11] (Berridge and Edwards 1987, p. 205). In Australia in 1905, by Proclamation, the Commonwealth Government declared absolute prohibition on the importation of opium suitable for smoking, and restricted the use of opiates to medical use only, under prescription (Manderson 1987, p. 6-8).

According to Manderson (1993), the use of narcotics in Australia at the beginning of the twentieth century was minimal, and therefore drug policy was not seen as particularly important; however, under pressure from other nations, Australia increased its drug controls. In 1912, Britain signed the Hague Convention on behalf of Australia and by 1913 the Australian Prime Minister Andrew Fisher made initial, although unsuccessful, attempts to enact uniform legislation across all the states (Manderson 1993, p. 63). As a signatory to the Hague Convention, Australia was required to enact laws to suppress production, trade and use of opium for smoking, and to restrict the manufacture, sale and use of opium, heroin, morphine and cocaine to medical and legitimate purposes (Manderson 1993, p. 62). By 1914, Australia's Opium Proclamation had restricted the importation of morphine, cocaine and heroin to ensure that importers could only sell to druggists and doctors (Brown et al. 2001, p. 1109). In the same year, America's first major national anti-narcotic law, the *Harrison Act 1914*, was enacted to prevent recreational narcotics use and the prescription of heroin to prevent withdrawal symptoms (Manderson 1993; Musto 1999). Clinics providing a legal source of drugs for users were forcibly closed and doctors were banned from treating addicts[12] (Musto 1999).

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[11] Legal controls were formulated under the influence of the anti-opium movement which created the myth of the mysterious threatening 'den' in the back streets of London's East End (Berridge and Edwards 1987, p. 195). In reality, smoking of opium among the Chinese was largely among Chinese seamen who used the drug as a stimulating aid to hard work, rather than as a distraction from work as commonly believed. According to Berridge and Edwards (1987), the myth of the opium den and the public reaction to Chinese opium smoking reflected imperialism and fears of economic uncertainty in which the Chinese were useful scapegoats (pp. 202, 205).

[12] Although this resulted in the formation of large illicit narcotics networks of supply and distribution by pushing addicts into stealing to buy drugs Musto (1999) cautions against attributing the creation of criminal addicts solely to the *Harrison Act*. By the early twentieth century, non-criminal addicts were already declining in numbers partly due to the changing prescribing practices of physicians and a growing public intolerance to drug use; this resulted in non-medical addicts becoming more conspicuous.

Medico penal rationality in drug treatment

At the end of the First World War, the League of Nations established an Advisory Committee on Traffic in Opium and Other Dangerous Drugs, comprising mostly colonial powers. The United States did not attend the League Committee, yet made it clear that America was committed to stricter drug controls (Manderson 1993, p. 70). In Britain, a dispute regarding treatment of opiate addiction shifted the focus of treatment from medico-moral models of reformation to maintaining the addict on their drug unless they preferred to undergo treatment to abstain. The debate was complicated by the introduction of the *Dangerous Drugs Act 1920*, which made possession of opiates a criminal offence, even though at the time of the introduction of the Act drug use was at its lowest ever level (Berridge and Edwards 1987, pp. 252-253; Berridge 1992). However, in 1926, the Rolleston Committee, chaired by Sir Humphrey Rolleston, President of the Royal College of Physicians in Britain, ruled that addicts could opt for drug maintenance and undergo a weaning off process by their practitioner; therefore addicts continued to be governed principally by the medical professional (Berridge and Edwards 1987; Departmental Committee on Morphine and Heroin Addiction 1926). The Rolleston Committee argued that addiction in Britain was rare, however the drug addict suffered from an illness, and medical maintenance would enable them to live a normal life without suffering the horrors of withdrawal (Departmental Committee on Morphine and Heroin Addiction 1926; Berridge 1999; Berridge and Edwards 1987). This humanitarian approach to addiction came to be known as the 'British system' (Seddon 2008). This system laid the foundations for contemporary harm reduction approaches, which will be discussed more in Chapters Two, Five and Six of this thesis. Seddon (2008; 2007b) argues that the implementation of the harm reductionist approach of the British system during the early twentieth century was partially related to a power struggle between professional interests. More broadly, however, it can be understood as a medico-legal regulatory technology in which medical and penal interests cooperate in a liaison under a common political rationality (Seddon, 2008; 2007b).

In the United States, the influence of psychiatry enabled drug addicts to be divided into categories of curable and incurable, or non-psychopathic and psychopathic. New psychiatric treatments and cures for opiate addiction were being trialled due to

perceptions that medicine had failed to find a cure for addiction (Musto 1999; Walmsley 2012). This is illustrated in a report from the New York *Mayor's Committee on Drug Addiction* to the Commissioner of Correction in 1930, which highlighted the need for a separation of categories of addicts and an articulation of methods of rehabilitation and reconstruction of their personalities. The report expressed concerns that repeated treatments for withdrawal and punishment were insufficient to control drug taking by addicts. The solution to the problem was seen to lie in custodial care combined with psychiatric and psychological intervention. According to the report, this would separate the psychopathic from the non-psychopathic types and avoid 'herding the curable and incurable together' or 'poisoning the mind of the non-criminal' (Lambert et al. 1930, p. 464). This blending of punishment and treatment laid the foundations for post-war practical developments in addiction treatment (Berridge 1990, p. 1032). Contemporary technologies of mandatory, court ordered drug treatments that have developed from these earlier treatment models are discussed in Chapters Five and Six.

In Australia, following the enactment of various Australian poisons acts, regulations extended to prohibition of the unlicensed sale of a wide variety of drugs, resulting in a steadily increasing number of drugs being restricted up to the 1920s and 1930s. These included cannabis, morphine, opium and cocaine, and a number of synthetic derivatives of opium and cocaine (Manderson 1987; Brown et al. 2001). Under the acts, state jurisdictions prohibited the prescription of a drug for the purposes of maintaining addiction. While this implied that Australia had rejected the British humanitarian approach and followed the punitive American model, in practice, prohibition was not heavily enforced and Australia informally followed the British system of medical prescription. Morphine and heroin continued to be supplied for the long-term maintenance of addiction, provided that the drug was prescribed by a medical practitioner and supplied by only one chemist (Manderson 1987, p. 106). Those who obtained drugs outside of medical supervision, however, were liable to arrest, hence, there was a clear distinction between the medically prescribed legal user and the illegal non-medical user (Manderson 1993).

Inebriates as a social problem

While the United States had implemented a range of punitive and corrective strategies to address drug addiction, and Britain had taken a compassionate, humanitarian approach of medical rather than punitive treatment, Australia's approach combined medical prescription with regulation (Manderson 1993). Addicts were supplied opiates through medical prescription, yet regulations preventing supply or prescription 'merely for the purposes of addiction' were in place. In essence policy remained within the control of medical authorities. Although there were some concerns about the morals of continued medical maintenance of addicts without efforts to enforce reduction or abstinence, the use of 'illegal' unregulated drugs was perceived as a sickness and a sign of evil (pp. 106-110). These concerns were, at least in part, related to a broader concern that inebriety was causing the degeneracy of Britons in the colony (Finch 1999). Inebriety was regarded as a hereditary condition that posed a threat to future generations of the colonies, and increases in physical and mental fitness and morality were considered to be fundamental to safeguarding the population from degeneracy. During the early twentieth century the Eugenics Society of New South Wales and the Women's Liberal League campaigned, on a platform of the nation committing 'racial suicide', for the promotion and education of temperance morality (Rodwell 2000). In 1911, the Australasian Medical Congress expressed concerns that Australia, as a young country in need of population, was rapidly losing population through inebriety. The committee reported that inebriety was a problem in need of urgent attention to enable every child to have the opportunity to become a more efficient citizen (Rodwell 2000). At the same time 'scientific temperance', underpinned by eugenic objectives, was introduced into the state school curriculum, linking temperance teachings to hygiene teaching (Rodwell 2000, p. 69). These middle class initiatives were underpinned by concerns about a declining birth rate, infant mortality, juvenile crime and inebriety and were intended to counter working class behaviour that was perceived to be the cause of racial degeneracy and social disorder (Rodwell 2000).

In post-war Australia, the Country Women's Association and the New South Wales National Party were instrumental in the introduction of compulsory temperance teachings for young girls in domestic science classes. The main concern was that,

upon entering marriage, women might neglect their cares and responsibilities for domesticity and parenthood and fall into the slovenly ways of the inebriate, and that their children could subsequently live a life of crime and misery on the streets (Rodwell 2000, p. 71). Boys, too, were encouraged, through school education programs, to do their duty as citizens and not be a burden on the community (Rodwell 2000, pp. 72-73). In 1936, the Eugenics Society of Victoria was formed through a collaboration of prominent social workers, whose interests were in racial hygiene, education and social welfare, to address sex education and family planning, as well as the prevention and eradication of venereal disease (Wallace 1962, p. 215). Mental deficiency bills presented to the Victorian Parliament in the 1920s and 1930s aimed to institutionalise and sterilise a large proportion of the population encompassing Aboriginal populations, and including those who were perceived as inefficient, such as inebriates, slum dwellers, homosexuals, prostitutes and those with a low IQ (McCallum 1998; Jones 2011). These bills were not enacted, due largely to the embarrassment of the eugenicist measures of the Holocaust (Jones 2011).

Similar concerns had been expressed by the Eugenics Society in Britain. Amid the mass unemployment of post-war Britain, fears of a degenerate, mentally deficient, 'social problem group' culminated in the Wood Report, produced by the Wood Committee in 1929. In his edited work *A social problem group?* the secretary of the Eugenics Society, C. P. Blacker, defined the social problem group as "destitute persons, of poor mental endowment, largely incapable of self-support and coming from families who have no means of supporting them" (Blacker 1937, p. 61). Those who were considered insane, beggars, the unemployable, criminals, epileptics and inebriates comprised the committee's definitions of social problems (Blacker 1937). Blacker concluded that physical and mental abnormalities could be transmitted from inebriate parents to their children, particularly the vicious and criminal tendencies exhibited by inebriates (p. 93). He and other members of the Eugenics Society favoured enforced birth control for 'mental defectives' (Berridge 1999). Seddon (2011a) and Berridge (1999) argue that there is a link between the eugenic views during the interwar years in Britain and concepts of contemporary problem drug users. Chapters Five and Six of this thesis highlight variations and mutations between Australia's 'dysfunctional citizens' and Blacker's 'social problem group', and contemporary notions of the problematic drug user of the twenty-first century. In

particular, the liberal notion of the functioning citizen and citizenship duties in colonial Australia can be linked to the functional, neo-liberal drug user whose drug use is defined as problematic only when it interferes with the individual's ability to function socially in areas such as employment, housing, finances and so on.

Tightening prohibition

Changing demographics of drug users

By the 1950s, all Australian states had enacted laws to prohibit the importation, sale, possession and use of heroin (Manderson 1993). Patterns of drug use remained relatively unchanged (Bull 2008) however, and convictions for illegal opiate use were rare, as most addicts were still able to obtain their drugs under medical supervision. These were middle class 'therapeutic' addicts, most of whom were aged over 50 years and their drug use had begun as a result of treatment with morphine for illnesses or chronic conditions (Manderson 1993, p. 133). The demography of drug addicts in Australia during this period was similar to Britain and continued to be so until well after the Second World War. Australia's consumption of heroin during the early 1950s was high by comparison with other countries, even though its use was generally restricted to therapeutic uses (Manderson 1993, p. 126). Although cocaine use among prostitutes and the 'underworld' attracted publicity and penalties, there were few links between drug use and crime, and addiction was not correlated with subcultures or subversive activities. Similarly, an analysis of the social characteristics of 454 British addicts from 1951-1959 indicated that a large number of addicts were working in medical and related occupations.[13] In contrast, in the United States, the addict was no longer a professional middle class man or a middle aged woman, but rather, a young, lower class, male, intravenous heroin addict, usually black or from other ethnic minority groups (Schur 1963; Courtwright 1982).

At the same time, marijuana prohibition in the United States was being shaped alongside campaigns emphasising immorality and degeneracy which associated marijuana with smoking Mexican immigrants, and the crime and deviance of Black

[13] The available sample was drawn from government reports, personal interviews by the author with narcotics officials from the British Home Office, interviews with physicians and psychiatrists specialising in addiction treatment, questionnaire responses of 13 British medical specialists, and information and interviews with 'addicts' in a variety of settings.

ghettos (Bonnie and Whitebread 1970, pp. 1035-1037). Bonnie and Whitebread (1970) argue that decisions to prohibit marijuana reflected public hostility for what marijuana represented, and intolerance toward deviant immigrants and despised minorities rather than concerns about the pharmacological effects of the drug (p. 1166). Public interest about the detrimental effects of marijuana was premised largely on perceptions of social problems associated with the use of marijuana, such as crime, poverty and insanity (Bonnie and Whitebread 1970, pp. 1166-1167). Similarly, in Britain, by the 1950s, cannabis had begun to receive more attention than opium due to increases in the number of cannabis prosecutions. The use of cannabis was linked to black seamen of London's East End, Negro theatrical performers and jazz musicians, and the 'problem' was seen to be confined to all parts of the country inhabited by a large, coloured, immigrant population (Spear 1969, p. 249). An increasing number of police raids on jazz and dance clubs in London and arrests of young people for marijuana, cocaine and opiates were, according to Spear (1969, p. 254), the first signs of an emerging drug subculture in Britain.

The politics of drug legislation

Bonnie and Whitebread (1970) argue that the public interest in marijuana prohibition in the United States during the mid-twentieth century was not simply a concern about a particular substance, but was part of broader anti-narcotics legislation and alcohol prohibition that condemned the use of all intoxicants (pp. 1166-1167). During the early 1950s, drug regulations were tightened in several jurisdictions in the United States, providing for harsher penalties for drug offenders. The legislative amendments resulted in a proliferation of marijuana offences and a further increase in penalties, yet Bonnie and Whitebread (1970) argue that these could not be justified in terms of the pharmacology of marijuana or the patterns of marijuana use and trafficking (p. 1077). Legislation did not distinguish between marijuana and other narcotics and there was a belief that marijuana was a dangerous drug leading to crime and was a stepping stone to 'harder', more addictive drugs. There was a particular concern about the use of marijuana among young people and harsher penalties were presented as the best way to eliminate illicit drug use (Bonnie and Whitebread 1970, p. 1079).

In 1946, the functions carried out by the League of Nations were transferred to the United Nations (UN), which delegated responsibilities to various subsidiary bodies. The United States had played a dominant role in the creation of the United Nations, and its subsequent influence over narcotics regulation. For example, US officials heavily influenced international conventions relating to narcotic drugs through the Commission on Narcotic Drugs (Bewley-Taylor 1999, p. 150). The head of the US Federal Bureau of Narcotics, Harry Anslinger, a zealous prohibitionist, had applied pressure on other nations to support transnational, prohibitionist legislation. It was in this context that communism became a platform for drug control (Bewley-Taylor 1999, p. 151). Manderson (1993, p. 123) argues that there were similarities between the fear of drugs and the fear of communism insofar as both were deemed responsible for social problems. The fear of drugs was a justification for anti-communist activities and the fear of communism was used as a justification for harsh responses to illegal drug use (Manderson 1993; Reynolds 1995). In the United States, references to the harm caused by narcotics linked the drug problem to international communism and China (Bonnie and Whitebread 1970). In particular, Anslinger tapped into American anti-communist paranoia to gain support for the punitive approach to narcotics use, by making allegations of Chinese communist drugs trafficking and claiming that communists were using drugs to subvert free nations (Bewley-Taylor 1999; Bonnie and Whitebread 1970). Between the 1930s and the 1950s, drug laws in the United States increased in severity to reach a peak in 1956, when the death penalty was applied to the sale of heroin to a minor (Musto 1999).

Following the Second World War, Australia formed close ties with the United States[14] based on defence interests and, according to Manderson (1993), the implementation of Australia's drug policy was heavily influenced by the United States (Manderson 1993). In Australia, 'dangerous drugs' had not previously been on the public agenda and were not seen as being an issue of great concern (Manderson 1993; Reynolds 1995). Despite pressure in 1949 from the World Health

[14] The United States used the war against the Japanese to further advance a prohibitionist drug policy by enforcing prohibitions on opium smoking in all liberated territories regardless of whether they had been British colonies before the Japanese invasion (Manderson 1993, p. 117). With Australia showing loyalty to the United States, Britain had little support or power to intervene and was forced to consent; opium smoking was subsequently prohibited in nations freed from Japanese powers (Manderson 1993, p. 118).

Organization's *Expert Committee on Drugs Liable to Produce Addiction*, to enact a total prohibition of heroin, medical professionals in Australia had rejected the proposal. There were few reported cases of addiction in Australia and there were concerns among the medical profession that prohibition would prevent the use of heroin for medical purposes, such as pain relief (Manderson 1993, p. 126). Nevertheless, Australia was committed to the international framework of drug controls and, in 1953, under international pressure, Commonwealth legislation was introduced to prohibit the importation, domestic manufacture, use and possession of heroin (Manderson 1993, p. 128).

The war on drugs

Expanding non-medical drug use

By the early 1960s, drug control had expanded to a large number of new substances, reinforcing the divide between legal, medical drug use and illegal narcotics used for non-medical abuse (Manderson 1993, p. 136). In 1961, the *UN Single Convention on Narcotic Drugs* was signed in New York, establishing a number of tight controls over the international and domestic drug trade and broadening the scope of regulation to include cannabis (United Nations Office on Drugs and Crime 2012a). Australia, as a signatory to the Convention, was bound to a system of drug control (Manderson 1993, pp. 136-138). From the 1960s, there were substantial changes in the patterns and quantities of drug use in Britain, the United States and Australia, due chiefly to the expanding availability of new, popular recreational drugs. In response, in 1964 the World Health Organization (WHO) introduced the concept of dependence, replacing and redefining the concept of addiction and encompassing the effects of the increasing variety of drugs available on the market[15] (World Health Organization 1969). By the early 1960s, there were few remaining 'therapeutic addicts' in Australia and the New South Wales government reported a concern about increasing diversity in drug use among young people, which included the use of amphetamines, barbiturates, cannabis and LSD (Manderson 1993, p. 144). In the United States the use of illegal drugs increased substantially with cannabis, heroin

[15] Berridge and Edwards (1987) argue that by generalising drugs and their effects the broader scope of the definition allows for a less stereotyped view of addiction and addictive drugs, yet at the same time allows for a broadening of the net of medical control (p. 245).

and LSD rapidly gaining popularity (Musto 1999). This surge in drug use, according to Musto (1999), was part of the enormous growth in the wealth of the United States during the 1960s and 1970s. In addition to an unparalleled market for consumer goods, including drugs, the population of young people aged 15 to 24 years had almost doubled within the decade, creating a large, potential drug market. There was also an increase in injecting heroin use from around 50,000 to approximately half a million during the decade (Musto 1999). The creation of drug 'sub-cultures' during the 1960s will be discussed further in the following chapter.

In 1968, President Nixon was elected on a platform of restoring law and order, particularly with regard to the problem of rapidly growing substance abuse (Musto 1999). At the same time, concerns of widening drug use in Australia were exacerbated by the arrival of large numbers of American soldiers on recreation leave from the Vietnam War, who brought with them large quantities of cannabis and heroin for sale and consumption (Manderson 1993; Brown et al. 2001). In order to address the American heroin addiction epidemic, a pilot heroin addiction treatment program, using methadone for outpatients, was begun by the Department of Corrections in 1969. It was expanded into the Narcotics Treatment Administration (NTA) which encompassed methadone treatment in addition to various forms of inpatient detoxification and outpatient abstinence treatment (DuPont 2002, p. 67). Methadone was hailed as a major breakthrough in combating heroin addiction and represented a more humane approach to the heroin problem than law enforcement (Musto 1999). Pharmacotherapy treatments, such as methadone, will be discussed in more detail in Chapter Three and Chapter Five.

Widening the net of regulation

In 1971, President Nixon launched America's War on Drugs, largely as a response to the problem of American soldiers becoming addicted to heroin in Vietnam and returning home with drug habits (Lintner 2002, p. 12). The United States subsequently strengthened its Drug Enforcement Administration (DEA) and collaborated with the United Nations to increase global narcotics control (Lintner 2002, p. 13). During the same year, the United Nations *Convention on Psychotropic Substances* of 1971 aimed to widen the net of regulation to include 'psychotropic substances', such as hallucinogens, including LSD and mescaline, synthetic

stimulants, such as amphetamines, and depressants, such as barbiturates, other sedatives and tranquillisers (Berridge and Edwards 1987; Manderson 1993). The following year the *Protocol Amending the Single Convention* was signed, granting the International Narcotics Control Board (INCB)[16] the authority to oversee and control a signatory's production of opium and the flow of drugs into the country (Manderson 1993, pp. 157-158). According to Levine and Reinarman (1991), the expansions of prohibition were a boon to organised crime and increased the numbers and types of people involved in illicit production and distribution (p. 473).

In Australia, the Minister for Customs and Excise from 1970 to 1972, Don Chipp, campaigned for increased law enforcement measures. Central to his efforts was the distinction between the unscrupulous drug 'pusher', who should be punished, and the addict, who needed treatment rather than punishment (Manderson 1993, p. 159). At the same time, Australian state jurisdictions enacted legislation extending police powers to search the premises of persons suspected of possessing or dealing drugs. Drug trafficking constituted a separate offence and an increased penalty of up to 10 years imprisonment was enacted for the supply or sale of drugs. Trafficking was determined by the possession of a quantity of drugs exceeding that which was deemed for personal use. The Commonwealth *Customs Amendment Act No. 2 1971* went further to create a separate offence of being in possession of a narcotic suspected of having been imported (Manderson 1993, p. 160). During the same period, Nixon created a Special Action Office for Drug Abuse Prevention (SAODAP) with a mandate to administer drug control resources for the Nixon government and develop government initiatives for research, treatment and prevention (Vrecko 2010a, p. 58). Unprecedented amounts of funding were committed to addiction treatment and research, and the subsequent development of drug abuse research centres opened up broad fields of drug research, which were underpinned by political interests (Snyder and Pasternak 2003, p. 200). Funding was made readily available for researchers whose projects could be aligned with the government's 'War on Drugs' (Vrecko 2010a, p. 59). When the US Congress passed

[16] The INCB is central to monitoring the implementation of the United Nations international drug control conventions. In collaboration with governments the INCB also coordinates the supply of drugs for licit purposes and the acts to prevent the diversion of licit drugs to illicit sources (International Narcotics Control Board 2012).

the *Drug Abuse Office and Treatment Act of 1972*, the way was opened for a vast expansion of clinical treatment programs and a range of research initiatives (Vrecko 2010a, p. 58). An addiction scientist, Jerome Jaffe, who was sent to Vietnam by President Nixon to understand how the heroin problem could be controlled, commented, decades later, that the research conducted during the Nixon era laid the foundations for the current treatment system (Jaffe 1999, p. 23). Current treatment systems that have developed from these earlier models will be discussed in more detail in Chapter Three and Chapter Five.

Conclusion

This chapter has reviewed historical and contemporary accounts from the nineteenth century to the early 1970s and has attempted to capture the nuances, complexities and contingencies that have made drugs and drug use a problem for governments in contemporary Western societies. During the nineteenth century, opium and its derivatives were transformed from being relatively benign substances to being dangerous drugs that required medical and legal regulation. The problem of opium use emerged at a time of immense political, economic and social change, as well as significant developments in public health and medicine, and was underpinned by biopolitical concerns of hygiene, race, class and the security of the nation. In colonial Australia, these anxieties focused on degeneration and the production of functioning citizens for the future of the colony. The regulation of drugs that resulted from these anxieties was not simply about problems of ill health or addiction, but was a consequence of a complex interplay of a range of social and political factors.

This chapter has identified continuities between the nineteenth century and the contemporary problematisation of drugs and drug use. Strands of the moral-pathological concept of addiction, which was shaped through an alliance between temperance campaigners and the medical profession during the nineteenth century, are evident in contemporary forms of rehabilitation. The liberal paradox between the irrational addict and the rational addict, evident in the insurance case of the Earl of Mar, remains strong in contemporary, neo-liberal, treatment programs that govern the drug user while simultaneously holding them responsible for their behaviour. Another thread of continuity identified in this chapter is the early problematisation of

the drug user, which accords with contemporary constructions of drug users as a 'social problem group' first identified by CP Blacker of the Eugenics Society during the 1930s. In particular, the liberal notion of functioning citizens, which was so important in colonial Australia, continues to be a dominant theme in contemporary constructions of problem drug use and drug users. Interview data will illustrate the continuation of these themes in Chapter Five and Chapter Six. The following chapters will also illustrate how the British system, which began with the Rolleston Report of 1926, has been instrumental in shaping contemporary, neo-liberal, harm reductionist governance.

The 'War on Drugs' was a significant turning point in the ways in which drugs are governed by the criminal justice system and the public health system. Contemporary treatments, punitive responses and rehabilitative programs, which have developed from the 'War on Drugs', will be explored further in Chapters Three, Five and Six. Chapter Three will explain how the work undertaken by Jerome Jaffe during the Nixon era, laid the foundations for current treatment systems that operate within a framework of harm reduction. The following chapter is a continuation of the current one, beginning from the 1960s when the drug problem became synonymous with the problem of young people.

CHAPTER THREE: REFRAMING THE DRUG PROBLEM FROM THE 1960s

The previous chapter traced some of the complex social relationships, and the political and economic arrangements that shaped the contemporary drug problem. The chapter continues from the previous one to review historical and contemporary sociological, criminological and medical literature on illicit[17] drug use, drug policies and drug practices. Beginning with a discussion of young people's drug subcultures and concluding with the contemporary governance of drugs, the purpose of this chapter is twofold: firstly, the chapter investigates developments in public health policy and law from the 1960s onwards, and the growth in young people's drug use and drug cultures that accompanied these developments. Secondly, the chapter reviews the literature on drugs and drug users, and identifies gaps in the literature which this thesis seeks to address.

This chapter is divided into three parts. The first part discusses how the problem of drugs became a problem of young people. The second part explores public health responses to illicit drug use with a focus on harm reduction policies. Thirdly the chapter reviews how the drug problem is governed in contemporary Australia through law enforcement and extra judicial functions. This includes a contemporary debate on the failure of law enforcement to achieve its objectives to reduce drug related harm.

A Problem of Drug Subcultures

Creating deviants

Expanding drug use

As mentioned briefly in the previous chapter, increases in drug use and the diversification of young people's drug use during the 1960s was due to the rapidly increasing variety of drugs available through expanding drug markets. This surge in

[17] In this thesis, the term 'illicit' encompasses the use of illegal drugs or the use of legal drugs that are used in ways not intended. For example, pharmaceutical drugs obtained by illegal prescription or injecting prescription drugs intended for oral use only. The terms 'illegal' and 'illicit' are used interchangeably throughout the thesis.

drug use was also part of an enormous growth in wealth between 1960 and 1970, particularly in the United States where a population boom almost doubled the numbers of young people aged 15 to 24 years (Musto 1999). During this period, it is estimated that, in the United States, the number of heroin users, mostly injecting users, rose from around 50,000 in 1960 to approximately half a million in 1970 (Musto 1999). Marijuana, heroin, amphetamines and LSD also gained popularity during this time of military draft for the Vietnam War and an ideology of protest, rejection of dominant values and 'dropping out' of traditional culture (Musto 1999; Davis and Munoz 1968). Against this social backdrop, drug use was typically viewed as a core element of bohemian subcultures, deviant communities and subversive social movements, in which young people shared common subterranean values and identities (Davis and Munoz 1968; Levine 1974). As mentioned in Chapter Two, drug-using subcultures had been of public concern since the late nineteenth century with the appearance of bohemian, occultist subcultures (Berridge and Edwards 1987, p. 205). Recreational cocaine and opium use had been part of the nightclub scene in London in the early twentieth century (Berridge 1988) and marijuana and cocaine characterised the jazz music scene in the United States and Britain (Spear 1969). By the 1940s, in the United States, large numbers of heroin users were injecting and intravenous drug use was widespread (Stimson and Choopanya 1998). Perceptions of the dangerousness of these drug users were, according to Walmsley (2012, p. 96), linked to medical representations of injecting drug users as carriers of disease spread through unsterilised syringes. This resulted in anxieties about the injecting drug user as 'diseased' and injecting drug use as an 'illness producing behaviour'. By the 1960s, the notion of disease had expanded to a more generalised conception of drug users as disease carriers. This is evident in Howard and Borges' (1970, p. 220) analysis of hepatitis infected drug users in the Haight Ashbury district of San Francisco during the 1960s, which found that 90 percent of hepatitis patients had:

> … at one time or another used drugs (marijuana, methedrine, LSD, hard narcotics, etc.) for the purpose of "expanding their minds or feeling high".

Further, the prevalence of hepatitis was linked to subcultural values of 'sharing', specifically with regard to drug users' living arrangements and the sharing of drugs and injecting equipment (Howard and Borges 1970, p. 225). Hence, the drug user was represented through public health discourse as an 'illness producing', dangerous,

subcultural subject (Walmsley 2012). At the same time, there were concerns about the ineffective treatment and regulation of addictive drugs and a professional and public focus on the social and psychological aspects of narcotics addiction (Cherubin 1967; Davis and Munoz 1968; Walmsley 2012). Perceptions of drug users as members of drug 'subcultures' generated a proliferation of research and literature on the ways in which young people use drugs. Ren (2005, p. 2) suggests that the study of subcultures was a part of the biopolitics of the population, which grew out of the development of knowledge of everyday life.

Deviants and delinquents

One of the most influential accounts of drug subcultures during the 1960s is Howard Becker's (1963) study of marijuana users presented in *Outsiders*. According to Becker (1963, p. 50-51) the enjoyment of marijuana is a learned process whereby the new marijuana user or 'novice' picks up from other users the collective meanings of being 'high' and applies these to their own experience. Once the marijuana user has experienced a high, they will continue to use marijuana for pleasure. Becker (1963, p. 9) argues that the construction of drug users as 'deviant' or 'outsiders' from their social group is a product of social labelling rather than of any inherent quality of the drug user. Since Becker's pioneering work, a number of social theorists have adapted elements of his work to studies of youth subcultures. These accounts variously conceptualise young people's delinquent and deviant behaviour as being the product of disenfranchised and underprivileged individuals of the working classes. These concepts have shaped cultural and social science literature that refers to 'youth subcultures' in terms of groups that engage in deviant or 'delinquent' behaviour and share collective values and norms (Cohen 1955; Cloward and Ohlin 1960). For example, in the 1960s and 1970s, neo-Marxist scholars, Stuart Hall and Tony Jefferson from the Centre for Contemporary Cultural Studies at Birmingham University, proposed that delinquency was a product of post-war subcultures that emerged out of structural changes in British working class neighbourhoods (Hall and Jefferson 1975).

Another highly influential work on social reactions to drug use and the construction of the drug experience is *The Drugtakers* by Jock Young (1971). Following Becker (1963), Young argues that opiate users do not experience a high until they learn how

to interpret the feelings they experience from the drug. In this regard, drug subcultures are important for 'socialising' people into a culture they find attractive. Young's investigation of the meanings assigned to drug use within specific cultures found that patterns of drug use are underpinned by social reactions to drug use and drug users, rather than any particular characteristic of the drug user. Expanding on Becker's concept of labelling, Stan Cohen's (1972) work on moral panics and the creation of mods and rockers in Britain, suggests that moral panics about 'deviant' groups create images of 'folk devils', such as drug addicts, rebels, bikers, paedophiles and so on. Folk devils are identified as threats to society and are stylised and stereotyped by the popular media, while experts denounce them and deliver a diagnosis and solution. Responses to such groups are not simply amplified, short-term social anxieties, but can produce changes in legal and social policy and in the ways that society conceives itself. In the context of subcultural membership, Levine (1974, p. 298) argues that 'addicts' generally identify themselves as a member of a particular subculture and the values of the group become their own, resulting in their becoming addicted to a lifestyle. In a similar vein, contemporary theorists have suggested that drug use rarely takes place as a solitary experience. This is because peer-groups, drug cultures, contacts within illicit drug markets and a quest for pleasure and entertainment are fundamental to framing the construction of the drug experience (Hammersley, Khan and Ditton 2002; Stewart 1987). Young people's experiences of drug use will be explored further through an analysis of interview data in Chapter Six.

Normality and problematic development

Earlier influential subcultural theorists include Clifford Shaw and Henry McKay (1942) of the Institute of Juvenile Research in the Chicago School of Sociology during the 1930s, who found that crime was correlated with particular neighbourhoods and linked to social change and upheaval. The influence of the Chicago School scholars is evident in an array of social science literature linking deviance to social pathology, social ecology, neighbourhood, family upbringing and environment. The Chicago School study has been criticised for its focus on lower class delinquency and the invisibility of middle class delinquency (Moore 2002, p. 23). David Moore (2002, p. 15) argues that, in Australian research of young

people's alcohol and other drug use, there is a disproportionate emphasis on pathology. This type of research generally situates the cause of addiction in a personality or environmental 'deficit', reflecting a broader emphasis on pathology in the addictions field. The pathology model also features in psychology and in public health literature, where drug use is grouped with other forms of 'antisocial behaviour', such as violence, truancy, teen pregnancy and crime. In these accounts, the causes of antisocial behaviour are typically attributed to individual dysfunction and pathology, dysfunctional families and poor urban neighbourhoods (McGee et al. 2009; Elkins et al. 2004). Variations of nineteenth century conceptions of the relationship between ill health, poor sanitation and inherent characteristics of the population are evident in these studies. Elements of these perspectives in discourses of young people's drug use will be illustrated using interview data in Chapters Five and Six.

Drug literature is overwhelmingly concerned with problems of individual and social pathology and criminality and, according to Moore (2002, pp. 15-16), the developmental model of 'adolescence' is the dominant model applied in drug studies of young people. The model has drawn on key figures in psychology, such as Freud, Piaget, Erikson and Bandura, and its ideas have shaped theory and practice in areas such as social work and teaching. A twin focus on biology and environment is central to the developmental model, locating adolescence in psychiatry and clinical psychology as a natural problem or condition to be treated. According to such accounts, there is an implicit assumption that 'normal' development of young people can safeguard against 'problematic' development. These have become ways of thinking about adolescence which fuse with institutionalised practices to produce self-conscious subjects who think and feel about themselves through these truths (Moore 2002, p. 19). 'Problematic' young people, as objects of governmental practices, will be illustrated through the use of interview data in Chapters Five and Six.

Young People's Contemporary Drug Use

The drugs young people use

The most popular drugs

According to data from the Australian National Drug Strategy Household Survey for 2011, young adults aged 20-29 years were more likely than other age groups to report using illicit drugs in the past 12 months[18]. The most commonly used drugs among this age cohort are cannabis, ecstasy, cocaine, hallucinogens and amphetamines, while heroin use and injecting drug use is more common in older drug users[19] (aged 30-39 years). Between 1991 and 2010, there was an exponential increase in the use of pharmaceutical opioids in Australia, notably methadone and morphine tablets known as oxycodone[20]. From 1990 to 2006, the number of morphine tablets prescribed in Australia increased 40-fold from 651,360 to 32.8 million (Nicholas, Lee and Roche 2011). Data from the Australian National Drug Strategy Household Survey (2010, p. 211) indicates that the use of pharmaceutical opioids for non-medical purposes, such as pethidine and oxycodone, is more popular than heroin use for every age cohort of drug users, with the exception of those aged 50-59 years. Although these substances are obtainable through legal prescription, their misuse is generally referred to as 'illicit' drug use. These drugs are generally obtained through stealing, falsifying or altering doctor's prescriptions, burglaries of pharmacies or surgeries, reporting imaginary or exaggerated symptoms to a GP, or purchased through drug market networks (Nicholas, Lee and Roche 2011; Stafford and Burns 2011). Xanax, a benzodiazepine that is prescribed as an anti-anxiety and sedative, and buprenorphine, which is prescribed in opioid substitution treatment, have also gained popularity among young people in recent years (Nicholas, Lee and Roche 2011; Stafford and Burns 2011). The use of these drugs in the current research cohort will be explored in Chapter Four and Chapter Six.

[18] A similar pattern of drug use occurs in Britain (Seddon 2006).
[19] In Australia it is estimated that just under two percent of the Australian population has injected drugs at some time in their lives (Australian Institute of Health and Welfare 2010).
[20] A synthetic form of morphine used as a pain killer.

Legal and herbal highs

There has been a global expansion of psychoactive chemicals available for pleasure, leisure or other consumption, including substances commonly referred to as 'legal' and 'herbal' highs. These substances have increased in popularity in recent years and have been distributed through a range of sources, particularly the Internet. Despite attempts to legally control the proliferation of these chemicals, the process can be lengthy and can be further complicated by differing legislation between the countries of the source and distribution points (Camilleri et al. 2010). Pharmacologically active chemicals are created when a structural or functional group is added to or deleted from a chemical to act on the central nervous system (Camelleri et al. 2010). Legal substances contain a slightly modified molecular structure of regulated drugs in order to circumvent drug legislation (Sacco and Finklea 2011). Substances may take the form of synthetic cannabis, party pills, energy powders and natural highs (Australia Legal Highs Forum 2012). Reports of the dangers of these substances focus primarily on Mephedrone, a relatively new 'party drug', also known as 'meow meow', which produces an effect similar to a mixture of MDMA (3,4 methylenedioxy-methamphetamine, popularly known as ecstasy), with a number of adverse side-effects (The Australasian Professional Society on Alcohol and other Drugs 2011; Motbey 2012). Although previously available as an unregulated substance, mephadrone has recently been added to Customs Regulations as a prohibited import (Australian Drug Foundation 2011). A study of synthetic cannabis found that the drug's legality was a significant contributor to its popularity. Although the 'legal weed' is reported to be cheaply and locally available through sex shops, tobacconists and the Internet, there are concerns about its side-effects and longer term effects on the user (Barratt, Cakic and Lenton 2012; Barratt and Bright 2012). The use of legal highs among young people will be discussed further in Chapter Five and illustrated using interview data from service providers.

Creating drug user typologies

Constructing identities

The previous chapter discussed the development of psychological typologies during the early twentieth century, which divided drug users into pathological and non-

pathological, and curable and non-curable. Psychiatry was central to understandings of whether or not a drug user was curable and the subsequent development of rational treatments for those who were deemed 'psychopathic' and, therefore, unable to control their use (Walmsley 2012; Levine 1974; Pates et al. 2001). This was illustrated in a report from the New York *Mayor's Committee on Drug Addiction* to the Commissioner of Correction in 1930, which highlighted the need for a separation of categories of addicts and an articulation of methods of rehabilitation and reconstruction of their personalities (Lambert et al. 1930). According to Lambert et al. (1930, p. 460), 'normal addicts' were not a serious problem to treat because most would voluntarily seek to rid themselves of their addiction. These typologies of drug users became tied to medicine and psychiatry, and continued to influence understandings of drug users throughout the twentieth century. This is illustrated in the account of Gay et al. (1974) of the 'pseudojunkie', whose identity as neither junkie nor non-junkie was problematic for psychiatric and psychological categorisation.

More recently, Fraser and Moore (2008, p. 746) have analysed how taxonomies of drug use as chaotic and ordered are integrated into policy documents, media, drug research and public discourse. They argue that representations of injecting drug users as chaotic establishes and polices boundaries between the ostensibly unproductive and disorderly lives of injecting drug users, and the normal, orderly and productive lives of non-injecting drug users. These taxonomies are not static, but rather contingent and arbitrary. Drug literature, policy and practice have defined illicit drug use according to whether it is considered 'dependent' or 'recreational'. This approach has been criticised for creating a false dichotomy that is underpinned by an assumption that a drug user must be one or the other (Moore 1992; Simpson 2003; Grapendaal, Leuw and Nelen 1992). It has been argued that the dependent/recreational divide does not allow for diversity in drug use and, in fact, it is often difficult to differentiate recreational from dependent drug use. For example, a dependent/recreational dichotomy fails to take into account poly drug users or those who use a diverse range of drugs in a variety of different ways (Simpson 2003, p. 310).

Self-constituted drug users

Coomber and Sutton (2006, p. 469) suggest that the categorisation of drug users is not restricted to externally imposed definitions, but is also a process of self-definition. They argue that drug user identity is produced through medical treatment and the criminal justice system, which ignore the social, psychological and contextual processes that are intertwined with how people use drugs and what they believe about their drug use. Further, the beliefs people have about their drug use are important to how they react to it (Coomber and Sutton 2006; Davies 1997). For example, although the concept of addiction is ambiguous (Coomber and Sutton 2006), people may interpret their drug use as addictive because it best serves their purposes and society's definitions of their behaviour (Davies 1997). Coomber and Sutton (2006) argue that drug user identities are contingent on a range of structural and individual circumstances, such as employment, relationships, peer groups and so on, in addition to beliefs about drug use that are formed within social institutions. The categorisation of drug users and the ways in which their beliefs about their drug use influence how they react to it will be illustrated using interview data in Chapter Six.

'Normal' drug use

In 1971, Jock Young argued that drug use could be understood in terms of subterranean values that are linked to an increase in the consumption of leisure in post industrial societies. Two decades later, Young (1999) argued that there had been an expansion of the night-time economy, such as night clubs and other forms of young people's entertainment, which have provided the focal point for a subterranean world of leisure involving drug and alcohol use (Young 1999). Based on a conceptualisation of this type of night time entertainment as normal, researchers at the University of Manchester developed the normalisation thesis during the 1990s (Parker, Williams and Aldridge 2002). Rejecting notions of pathology and social dysfunction as primary factors in the aetiology of illicit drug use, the normalisation thesis proposes that recreational, illicit drug use is part of a broader search for pleasure, excitement and enjoyment in young people's consumption-oriented, leisure lifestyles. It is argued that drug subcultures of the 1950s to the 1980s were replaced by a normalisation of drug use from the 1990s onwards. The idea of drug use as a

subcultural practice is replaced by drug use as a practice that has become the norm among young people in the past few years. From this perspective, it is argued that non-drug using youth could eventually become a minority, deviant group (Duff 2005; Parker, Williams and Aldridge 2002; Parker, Aldridge and Measham 1998; Measham and Shiner 2009). Measham and Shiner (2009, p. 505) argue that the conceptualisation of youth drug use, as a part of the consumption of cultural and stylistic practices and shared identity within a rapidly expanding night-time economy, has reawakened interest in classical, subcultural perspectives of the 1970s. However, others have suggested that it is difficult to apply the notion of subcultures to young people who use drugs in the context of parties and clubs. This is due to the diversity of young people who use party drugs and their apparent normality in 'blending back into mainstream society' once they 'recover from the fun' (Sanders 2006, p. 3).

The use of party drugs, then, tends to be portrayed as recreational, rational, informed and normal, rather than exceptional (Measham, Aldridge and Parker 1998; Measham and Shiner 2009). Ecstasy, as a party drug, is commonly associated with dance culture and is a drug typically used by middle class, young people (Gourley 2004; Hammersley, Khan and Ditton 2002). A study by Hammersley et al. (2002, p. 132) of young ecstasy users in Britain found that the majority of the participants were middle class, single, tertiary educated and employed or studying. They lived in a peer-world where drug taking was considered normal and rational. Despite having an awareness of the legal risks associated with the use of illicit drugs and the potential health risks linked to ecstasy use, the participants were willing to take calculated risks for the entertainment and pleasure they derived from ecstasy. The researchers reported that the ecstasy users appeared to be normal, polite, cooperative and intelligent members of society. Similarly, an Australian study of ecstasy users found that young people regarded ecstasy as a legitimate form of entertainment. All the study participants were middle class university students and full-time workers who used ecstasy to enhance their mood and relax after a week of work or university. Despite the pleasure they derived from using ecstasy, they identified norms of conduct and social sanctions surrounding its use, including condemnation of compulsive use, and practices of moderate and acceptable use (Gourley 2004, p. 69).

The findings of the current research for this demographic of drug user are presented in Chapter Six.

Dependent drug users

As discussed in Chapter Two, the addict was created through a convergence of nineteenth century anxieties of the rapidly developing, industrial state and the interests of middle class, medical professionals. Psychology and medicine played a key role in creating the pathological drug user and the drug addict as an individual with particular psychological and physiological characteristics, such as an 'addictive personality' or a flawed gene (Bull 2008; Hammersley and Reid 2002; South Australia, Royal Commission into the non-medical use of drugs 1979; Heyman 2009; Leshner 1997; Levine 1978; O'Brien and McLellan 1996; Jellinek 1960). In the latter part of the twentieth century, a variety of addict identities, such as the habitual user, the HIV/AIDS risk, the criminal and so on, became tied to wider processes of governance and control in neo-liberal societies (Reith 2004, p. 290). Around the same time, as discussed in the previous chapter, the term 'dependence' was introduced to replace addiction, as a way to capture a broader range of substances and their various psychological and physical effects (World Health Organization 1964). While there have been criticisms and endorsements of the WHO change, Moore (1992, p. 462) argues that the substitution of addiction for dependence did not change the reliance on clinical observation of treatment populations as the basis for diagnosing dependence. There is little known about drug dependence outside of the clinical environment and, as most drug use occurs in non-clinical settings, clinical conceptualisations of dependence may not even be relevant to community settings. Moore (1992, 486) suggests that, if drug dependence does, in fact, exist, the clinical paradigm is unhelpful because it obscures important elements of how dependence is constituted by the social processes that characterise a given social context of drug use. Similarly, Coomber and Sutton (2006, p. 463) argue that the therapeutic setting is an inadequate environment for assessing dependence within the 'real world', because it is free of other confounding factors that might interrupt continued use.

Other views on drug addiction and dependence include the radical perspective of Thomas Szasz (1998) who denies any real pharmacological basis for addiction. Rather, Szasz (1998, p. 157) argues, addiction is a construct of social, political and

cultural factors; people are taught that they are unable to resist the temptations of substances such as alcohol and drugs, and their unwillingness or inability to do so constitutes a disease. According to Szasz (1998, p. 156) medicine has replaced religion in most areas of social life, including drug controls, and has resulted in the development of a 'therapeutic state'. Coomber and Sutton (2006, p. 469) take a more moderate approach, arguing that no one really knows how long it takes to become addicted to a substance, although their study suggests it could take longer than 12 months for a person to become addicted to heroin. The period of time to become addicted is, nevertheless, socially and culturally contingent, and interwoven with personal circumstances that significantly contribute to the duration of the addiction. Coomber and Sutton's (2006, p. 469) study findings have implications for how drug users react to their dependency and also for policy and practices in terms of medical treatment, and in criminal justice. With few positive reinforcements of people moving between stages of use, or beyond addiction, drug users accessing services come to believe they have a chronic condition that can only be overcome through substitute prescribing, counselling and various other forms of self-help, such as reconstitution through spirituality or religion[21]. These discourses of 'help' are integrated into rehabilitative services and treatments, and will be discussed further through an analysis of interview data in Chapter Six.

[21]Narcotics Anonymous (NA) is an example of one of the self-help groups that, as suggested by Coomber and Sutton (2006), incorporate spirituality and religion, and can reinforce individuals' subjective identification with a chronic condition and an essential fixed, unchanging 'addict' identity (Reith 2004, p. 292; Heyman 2009). This is illustrated in Narcotics Anonymous' description of the character of the addict as "a man or woman whose life is controlled by drugs … people in the grip of a continuing and progressive illness whose ends are always the same: jails, institutions and death" (Narcotics Anonymous 2008, p. 3). The NA addict admits to being powerlessness over their addiction, and members of NA have variously described their drug use in terms of a self-imposed life sentence which places them in a situation of lifelong recovery. Narcotics Anonymous members have stated that they seek help from NA because the program works miracles in their lives to help them live without drugs (Narcotics Anonymous 2008). Paradoxically, in spite of NA members' powerlessness over their addiction, their success stories are testimony to their ability to voluntarily abstain from drug use permanently (Heyman 2009). Reith (2004) suggests that this type of self-constitution of addiction is not simply a discursive object but is made real for those who subscribe to the notion of its determinism (Reith 2004, p. 292).

The problem of pleasure

Pleasure and the recreational/habitual divide

Social class, rather than simply the physical or psychological effects of particular substances, may be a primary determinant of whether or not various forms of drug use are deemed problematic. This problematisation of drug use is interwoven with representations of 'recreational' drug use as an activity of unproblematic, middle class drug users having fun, and 'dependent' drug use as working class and pathological. The use of recreational drugs is generally regarded as experimental and a pleasurable, relatively harmless activity of young people who are not alienated from society, nor addicted to drugs or involved in delinquency or crime (Gourley 2004; Seddon 2006). Dependent drug use, on the other hand, tends to be conflated with injecting drug use, poverty, marginalisation, addictive drugs, and a problematic, chaotic lifestyle characterised by criminal activity and prolonged individual lack of control (Valentine and Fraser 2008). O'Malley and Valverde (2004, p. 39) argue that these categories of drug users are discursively linked to reason, where moderation is akin to the experience of pleasure, and dependency is associated with compulsion and a pathological pleasure deficit. Chapters Five and Six will illustrate how these categories are not simply ways of understanding drug use, but are tied to a set of neo-liberal governing techniques which justify a variety of appropriate responses.

The experience of pleasure in relation to ecstasy and other party drugs has been widely examined (Hammersley, Khan and Ditton 2002; Measham, Aldridge and Parker 1998), yet few authors have discussed pleasure in relation to injecting drug use, or drugs thought to be addictive such as heroin or methadone (Valentine and Fraser 2008). This is due to conceptions that the use of these substances is motivated primarily by social, environmental or individual pathology (O'Malley and Valverde 2004; Valentine and Fraser 2008; MacLean 2005). Hence, the correlation of problematic drug use with other 'social problems', such as crime and social disorder, prioritises social determinants over capacity for agency (Valentine and Fraser 2008). However, the context of the drug use and who is using the drug influences whether drug use is considered problematic. Valentine and Fraser (2008, pp. 410-411) argue that a drug such as cocaine may be deemed 'recreational' and pleasurable when used among middle class professionals, yet harmful and linked to crime, social problems

and addiction when used by the impoverished and socially marginalised. An analysis of interview data in Chapter Six will further explore pleasure in drug use.

Dependent pleasures?

Researchers who acknowledge the experience of pleasure outside the realm of 'recreational' drug use have argued that emotions such as fear, excitement, anxiety and risk are part of the pleasure experience of injecting drug use (Fitzgerald et al. 1999; Stewart 1987). Others have argued that pleasurable drug experiences can be shaped by the institution of social sanctions, for example, the 'thrill' of using 'dangerous', illegal drugs (Fagan and Chin cited in Fitzgerald et al. 1999; Duff 2007). There has also been debate on whether pleasure said to be derived from the experience of injection is indicative of a phenomenon of 'needle addiction' (Walmsley 2012; Pates et al. 2001; Levine 1974). Similarly, pleasure tends to be absent from literature on other types of substance use thought to be motivated solely through pathology, such as inhalant use. MacLean (2005, p. 296) argues that literature on 'chroming'[22] is overwhelmingly clinical, attributing causes to pathologies, including family dysfunction, psychiatric co-morbidity, delinquency, drug addiction and adverse health effects. In her study of young people's pleasurable experiences of inhaling aerosol products MacLean (2005, p. 312) found that chroming offers pleasure, variety and excitement for young people, especially those who otherwise have little buying power to enjoy the pleasures of consumption. It would appear that the motivating factor in MacLean's analysis is pleasure and affordability, rather than pathology.

Public Health: Reframing the Drug Problem

A social problem to socially productive citizens

Managing the problem through the clinic

As discussed in the previous chapter, it was during the 1960s that the Nixon government pledged its commitment to developing addiction treatment programs that were aligned with political interests. In this political context Jerome Jaffe's research

[22] Chroming is an Australian term for inhalant use involving aerosol paints (MacLean 2005, p. 295).

and development of addiction treatments provided a basis for current treatment systems (Jaffe 1999, p. 23). At the same time, in Britain, addiction treatment was moving away from institutions to clinics; a shift which Seddon (2010, p. 83) argues, reshaped the 'medical gaze' from a focus on the individual doctor-parent relationship to the medical containment of the drug problem. According to Lart (1998) the clinic system served a dual function of providing treatment while controlling the drug problem. More broadly, Seddon (2010, pp. 84-85) argues that the clinic system represented a new 'problematisation' of the drug problem connected with the transition to neo-liberalism. The clinic was a neo-liberal technology of risk management; a way of organising drug users who were perceived as potential disease carriers and criminals, and therefore, as harmful to themselves and the community.

Within the clinic, psychiatrists became authorities over the care of the addicts who were prescribed heroin with the purpose of controlling the epidemic of heroin use (Lart 1998, p. 62). According to Mold (2004) there was also a reconceptualisation of drug addiction as a social problem which underpinned treatment practices at the clinics. This was partially due to heightened fears about drug use resulting from the growing numbers of young, working-class, recreational drug users at the time. It was, however, also due to a redefinition of the relationship between medicine, disease and society, which relocated addiction as both a problem that required additional control, and a social disease that required treatment. As the medical gaze widened from the individual body to the social body, epidemiology in public health policy became a way of viewing addiction as a biopolitical problem of infectious disease (Mold 2004, p. 502).

Producing socially productive citizens through pharmacotherapy

The focus on drug addiction as a social problem underpinned treatment policies in British clinics that were more concerned with curing drug addiction, rather than maintaining addicts on heroin. As a result, prescriptions for heroin were gradually replaced with oral methadone dosing (Mold 2004, p. 515). For American pioneers of the methadone treatment, Vincent Dole and Marie Nyswander (1967, p. 20), methadone was fundamental to producing socially productive citizens who could live socially acceptable lives. In Australia, Methadone Maintenance Therapy (MMT) was first used as a treatment option in Australia in 1969 (Bull 2008). It is the oldest and

most commonly prescribed treatment for opioid dependence and, in 2011, 69 percent of clients seeking treatment for their drug use were prescribed methadone maintenance treatment[23] (Tait et al. 2008; Australian Institute of Health and Welfare 2012). Another common pharmacotherapy prescription maintenance program is administered through the synthetic opioid buprenorphine-naloxone which reduces the desire for heroin (Australian Institute of Health and Welfare 2012). The opioid antagonist naltrexone is also used to treat a range of conditions such as opioid addiction and gambling (Vrecko 2010b).

Rational management through harm reduction

Conceptualising harm reduction

Various concepts of harm reduction that emerged from the 1960s to the 1980s in Western nations were shaped, in part, by the UN Single Convention on Narcotic Drugs of 1961 and the UN Convention on Psychotropic Substances of 1971. The conventions stressed the need for drug demand reduction, in addition to measures for the prevention of drug abuse, and the provision of drug treatment, education, rehabilitation and social reintegration (International Narcotics Control Board 2010). The rationale of harm reduction to reduce harm to society and to the individual has, however, been around since the 1920s and was, according to Berridge (1992, pp. 58-59), a consistent theme in British drug policy during times of 'war time crisis'. The principle of harm reduction was part of the framework of maintenance prescribing outlined in the *Rolleston Report* of 1926, which was discussed in the previous chapter. Berridge (1992, p. 61) argues that the notion of harm reduction through drug maintenance was not, however, simply a way of reducing harm to the drug user and the community, but was also a means of allowing the addict to lead an economically productive life. Looking further back to the 1840s, this rationalist objective of harm minimisation is a variant of the public health rationale of the health and human capital arguments of the social reformer Edwin Chadwick, which were outlined in Chapter Two.

[23] Methadone was first discovered by the German pharmaceutical industry in 1941 during the Second World War when Britain stopped exporting heroin to Germany (Manderson 1993, p. 118). It was rediscovered in the 1960s as a treatment or long term maintenance option for opioid addicts in New York; by 1970 New York City had 20,000 patients (Berridge and Mars 2004).

In Britain during the 1960s, harm reduction was initially the domain of workers, doctors, and policy-makers who were committed to politically and socially opposing the legal sanctioning of drug users (Roe 2005). While the 1970s had favoured an abstinence based approach to habitual drug use, fears of a global AIDS epidemic in the mid-1980s gave way to major drug policy shifts (Mold and Berridge 2010, p. 109). Contemporary harm reduction strategies can include abstinence or a reduction in drug use, however the primary goal of harm reduction is to promote safer drug use (Lenton and Single 1998). The logic underpinning harm reduction policy is that the threat of HIV to the community outweighs the threat posed by injecting drug use (Ritter and Cameron 2005, p. 5) Nevertheless, there is no universal definition of harm reduction and the ambiguity of the concept has resulted in a multitude of definitions and debates based on a variety of conceptualisations[24] (Des Jarlais and Friedman 1993; Lenton and Single 1998).

The major concern of the HIV/AIDS epidemic for health professionals during the 1980s was the risk that the virus could spread from injecting drug users to the wider population through sexual transmission (Robertson et al. 2006; Bull 2003; Walmsley 2012). Harm reduction subsequently became identified with HIV/AIDS prevention and also with addictions treatments (Roe 2005). During the 1980s opponents of drug prohibition formed a coalition with public health and other 'mainstream' groups to mobilise community harm reduction responses and clinical interventions in order to contain the disease (Plummer and Irwin 2006; Roe 2005). At the same time, drug users became outspoken advocates of harm reduction, particularly the provision of clean injecting equipment. 'User groups', AIDS activist groups and self-help organisations were collectively advocating and campaigning on behalf of drug users, giving them the status of 'lay expertise', and by the late 1980s drug users were an integral part of drug policy debates (Mold and Berridge 2010, pp. 111-112). Despite tensions between those who favoured abstinence and rehabilitation, and those who advocated harm reduction, the reduction of harm took precedence over eliminating drug use. Community-based strategies such as needle syringe programs were subsequently developed to reduce the risk of drug users spreading HIV to the general

[24] Single (1995) argues that a broad definition of harm reduction is preferable, directed to reducing adverse health, social and economic consequences of drug use (p. 289).

population. This also ensured that the drug using population was brought into services where they had access to harm reduction information and equipment, such as clean syringes (Mold and Berridge 2010, p. 109). While methadone was already being prescribed as a short-term treatment to achieve abstinence, Mold and Berridge (2010, p. 110) argue that it became part of the bait for bringing users into drug services, and making drug users more visible at the level of policy and practice.

Harm reduction technologies

In Australia, the National Drug Strategy provides a policy framework based on the assumption that drugs are essentially harmful. According to the policy document, the policy framework focuses on improving health, and social and economic outcomes for the community and the drug using individual (Ministerial Council on Drug Strategy 2004). Harm reduction strategies that meet the objectives of the National Drug Strategy include Needle Syringe Programs[25] (NSPs) which provide free syringes and other injecting equipment to injecting drug users. NSPs also provide education on reducing drug use, health information and referral to drug treatment and medical, legal and social services (Dolan et al. 2005). Another harm reduction strategy is the Supervised Injecting Facility which provides a hygienic, legal space for injecting drug users to inject their own illegal and illicit drugs (Ritter and Cameron 2005, p. 22). Although there are around 60 formally recognised supervised injecting facilities operating in European countries, the only injecting facility in Australia is the Sydney Medically Supervised Injecting Centre (MSIC) (van Beek 2003). The MSIC is a clinical service developed to reduce public health and public order problems arising from street-based injecting practices. The centre provides clean injecting equipment in an attempt to reduce the transmission of HIV, hepatitis B and C, and the 'public nuisance' associated with public injecting. It also provides health information and/or drug education and responds to drug overdoses should they occur (van Beek 2003, p. 626).

[25] A large number of NSPs are in existence in Australian cities and regional centres. According to program evaluations NSPs have been successful in reducing the prevalence of hepatitis C and HIV/AIDS (Crofts et al. 1997; Ritter and Cameron 2005).

Stigma, and the government of contagion and threat

At the end of 2008 approximately 17,444 people in Australia were infected with HIV (Australian Institute of Health and Ageing 2010). Most literature concerning blood borne disease is directed at people who inject drugs and therefore there is an automatic conflation of viruses such as hepatitis C and HIV with drug use (Fraser 2011, p. 96). This results in the stigmatisation of drug users as 'diseased' individuals following their diagnosis with infectious diseases such as hepatitis C or HIV. This was illustrated in Pugh's (2008) analysis of media representations of people with hepatitis C, which found that infected individuals are typically portrayed as either 'innocent victims' who have acquired the virus through blood transfusions or other medical interventions, or as guilty perpetrators who acquired the virus during injecting drug use. This binary reinforces notions of injecting drug use as inherently bad and detrimental to the health of individuals and the wider community.

In recent years, individuals who have been perceived as not adequately governing their infectious blood-borne disease, have been considered a contagious threat, and forcibly isolated or incarcerated (Lupton 1995, p. 54). This was illustrated in John Scott's research of an HIV-positive prostitute, Sharleen Spiteri, who in 1989 was forcibly detained in New South Wales and forced to seek medical treatment and psychological counselling (Scott 2003, p. 283). On account of the Spiteri case, the *Public Health Act* (1902) was amended to enable penalties of a fine or six months prison for persons found to be recklessly endangering others by spreading disease (Scott 2003, p. 283). A key objective of the amendment was to ensure a balance between issues of individual rights and public health; in practice this allowed for more intense monitoring and supervision of at-risk populations (Scott 2003, p. 283), such as prostitutes and injecting drug users[26].

Criticisms of harm reduction

By the 1990s drug policy was as much concerned with the reduction of drug related crime by limiting the availability of drugs, as it was committed to reducing health risks associated with drug use (Mold and Berridge 2010, p. 129). These objectives

[26]Similarly, in 1994, a man in a small town in Victoria was arrested and charged for allegedly spreading HIV by not using safe sex practices (Lupton 1995, p. 54).

are encompassed in contemporary harm reduction policies that are directed at supply reduction, demand reduction, and harm reduction. Harm reduction is intended to support active drug users in the prevention and reduction of harm. Supply reduction is in effect law enforcement, while demand reduction focuses primarily on abstinence or rehabilitative strategies (Ministerial Council on Drug Strategy 2004). According to the UN, demand reduction programs should be integrated into social welfare programs, health policies and preventative education to ensure an environment where healthy choices became attractive and accessible (United Nations 1998b). There have however, been numerous criticisms of the integration of law enforcement into the harm reduction framework. These criticisms are concerned with the antithetical combination of attempting to reduce harm to drug users, while increasing harm by criminalising drug users through law enforcement (Miller 2001; O'Malley 1999; Lenton and Single 1998; Wodak and Moore 2002).

Contemporary harm reduction policy adopts an apolitical, value-neutral approach that does not engage in political criticism of prohibition (Roe 2005). This, according to Miller (2001), allows for the continuation of harm without governments accepting responsibility for, or acknowledging, the social, legal and economic source of those harms. Miller (2001, p. 177) argues that this exemption of responsibility is part of a decentralisation of power in neo-liberal societies, from the state to the local and individual levels. Harm reduction enables risky, potentially disease-spreading, drug using populations to be identified through drug services, and guided in responsible, self-regulatory, safe, drug use practices. As such, they become active citizens in managing their own risk (Dean 1999, p. 168) and act as responsible consumers through their harm reductionist drug use practices (Seddon 2010, p. 87). At the same time, this combination of economic rationalism and social policy relieves political and criminal justice institutions of responsibility for the effects of criminalisation, by assigning responsibility to individuals for managing their drug use (Roe 2005, p. 247). Miller (2001, p. 177) argues that while harm reduction as a policy approach represents the most promising advance in drug policy, many of the claims made by proponents of harm reduction strategies are flawed, inadequately addressed or overly simplistic. A key problem is that harm reduction claims to be amoral, yet its public health approach constitutes a moral ethic of the duty of a citizen to maintain health. Harm reduction technologies in contemporary Australia are discussed in Chapter

Five. The ways in which they shape young people's drug use practices is discussed in more detail using interview data in Chapter Six.

Drugs, Crime and Social Disorder

Causality and the drugs/crime nexus

Conflating illegality with harm

The idea of a causal link between drug addiction and crime forms the basis of an abundance of academic drug research and governmental reports (Hall and Lucke 2010; Ball, Shaffer and Nurco 1983; Chandler, Fletcher and Volkow 2009). According to Seddon (2006) this drugs/crime nexus has become 'self-evident' in policy circles (p. 680). According to Moore (2002) the disproportionate focus in research on drugs as a problem of crime has shaped and reinforced various 'truths' about drug use and the people who use drugs (Moore 2002, p. 2008). Others have argued that policy conflates legal status with chemical effects, and the focus on prohibited substances as necessarily harmful has created confusion and inhibited the debate regarding legality and harm (Hammersley and Reid 2002; South Australia, Royal Commission into the non-medical use of drugs 1979; Manderson 1993; Carney 1987). According to Hough (2001, p. 429) the focus on drugs as a problem of crime imbalances political and popular discourse about drug issues and equates illicit drug use with problematic drug use and extensive criminality. He argues that, during the 1980s and early 1990s in Britain, the focus of the drug problem was predominantly HIV/AIDS, however, more recently, this has been usurped by drug related crime.

While there is little doubt of a link between drugs and crime, the linkage is complex and dependent upon a number of factors other than drug use per se. Before the 1980s in Britain and Australia, problems such as crime related to drug use were relatively few (Seddon 2006; Parker and Newcombe 1987). However, the availability of large quantities of heroin in Britain during the late 1970s to early 1980s saw an escalation of heroin users, particularly among young unemployed people living in the poorest neighbourhoods (Seddon 2006, p. 683). The use of heroin subsequently became linked with social disadvantage, drugs and crime (Parker and Newcombe 1987). The

'fact' of drug related crime and socio-economic disadvantage however, remains relatively unexplored as no direct causal link has actually been found between crime and drug use and there is nothing inherently criminogenic about drug use (Bull 2010; Seddon 2006). According to Seddon (2006, p. 695), the association between the 'drug problem', crime and social exclusion, has only existed since a tightening of punitive drug policies during the 1970s and 1980s. These measures resulted in a disproportionate focus on the activities of socially and economically deprived groups.

The link between drug use and crime is often attributed to the use of dependent drugs, however it appears that problematic, dependent, chaotic, risk-taking drug users represent quite a small proportion of the total number of illicit drug users (Hough 2001, p. 430). Those who engage in 'problematic' drug use as defined by criminality, social, psychological or physical problems related to their drug use comprise a minority of people who use illegal drugs (Seddon 2006, p. 681). The difficulties in establishing a link between drug addiction and criminality is illustrated in research by Grapendaal, Leuw and Nelen (1992, pp. 307-308) who found that criminality is no more than a secondary characteristic of illegal drug use. They argue that there are no inherent characteristics of illegal drugs that lead to criminality among users. Rather, criminality and other social and health problems connected with illegal drug use are related to the social conditions of the drug use, rather than the pharmacological substances. The results of their Dutch study of 150 drug users found that regular drug users can regularly adjust the amount of heroin or cocaine they use, according to the amount of money they have available. This suggests, firstly, that the use of 'dependent' drugs, such as heroin and cocaine, does not restrict an individual's ability to make rational choices. Secondly, it indicates that patterns of heroin use may be dependent on the availability of money, rather than physical need (Grapendaal, Leuw and Nelen 1992, p. 311).

Theorising the drugs—crime link

A number of theories have been proposed to explain the link between drugs and crime. It has been argued that a regular drug habit is most likely to occur where the

person lacks other commitments, such as employment, which are inconsistent with maintaining a lifestyle of heavy drug consumption (Pearson 1996; Zinberg 1984).[27] Pearson (1996, p. 115) argues that, where young people experience social inequalities in educational and employment opportunities, alternative systems of status, achievements and rewards can be established in drug subcultures. In this context, Seddon (2006, p. 687) argues that, when heroin became abundantly available during the late 1970s, it opened up opportunities for a commodity exchange and consumption in communities with few other economic sources of material gain. Similarly, Bourgois (1998) suggests that drug users might construct a material lifestyle around the illicit drug industry if employment within mainstream culture is unavailable because of racial, social or political disadvantage. This does not mean that people begin to use or deal drugs because there are no alternatives, rather, where participation within mainstream culture is restricted they may seek out the material rewards of illicit industries (Bourgois 1998).

Drug law enforcement and punishment

Expenditure and cost

In 2012, the US National Drug Control Policy reported that the National Drug Control Budget would spend $26.2 billion to reduce drug use and its consequences in the United States, including $9.5 billion committed solely to domestic law enforcement efforts (Office of National Drug Control Policy 2011). Although it is difficult to obtain up-to-date data on resources committed solely to drug law enforcement efforts in Australia, it is estimated that annual funding is around $210 million (Moore 2005). The key objectives of drug law enforcement are to deter potential drug users through the threat of punishment, and to limit the availability of drugs and subsequently reduce the risk of harm to the individual and community (Mazerolle et al. 2007). Yet, an Australian evaluation of literature on drug law enforcement activities in Australia, Canada, the United Kingdom and the United States found that many police drug interventions[28] are largely ineffective in reducing

[27] In Australia, the highest proportion of recent drug use is among those who are unemployed (Australian Institute of Health and Welfare, 2011).

[28] The police drug interventions evaluated included drug crackdowns, undercover police work, crop eradication and intensive policing.

drug activities such as injecting drug use, drug dealing, and drug offences (Mazerolle et al. 2007).

Incarceration is thought to play a fundamental role as a deterrent to crime, yet prison statistics indicate that individuals convicted of drug offences and drug related crimes comprise an increasingly large percentage of prison populations. In 2011, drug offences comprised 10.7 percent of the Australian prison population (Australian Bureau of Statistics, 2011) and it is estimated that around 80 percent of prisoners are incarcerated for offences relating to drug use (NSW Select Committee on the Increase in Prisoner Population 2001; Johns 2004; Makkai and Payne 2003). Data from the Western Australia Department of Corrective Services indicates that the prison population comprises at least 70 percent illicit drug users (Western Australia, Department of Corrective Services 2010). Similarly, results of the Drug Use Monitoring Program (DUMA) (2012) found that 66 percent of police detainees tested positive to at least one illegal or illicit substance[29] (Sweeney and Payne 2012). A similar pattern of incarceration resulting from drug crimes and drug related crime has occurred in the United States where drug arrests, as a proportion of total arrests, more than doubled between 1980 and 2006 (Benson 2009, p. 5).

Who are the prisoners?

Although there is no direct causal link between social class and crime, prison populations have been found to be characterised by high levels of disadvantage in terms of education and skills, employment history and health. This is to some extent due to the types of crimes committed by people from poorer backgrounds, such as street crimes including possession of drugs, street assaults, or robberies that are easily detected by police and easily prosecuted (Tittle and Meier 1990; Gale and Wundersitz 1989). In Australia in 2007, between 40 and 50 percent of prisoners had not completed schooling beyond Year 10, and only five percent had a university qualification (Australian Institute of Criminology 2009). It has been estimated that globally, around a half of all young people who use drugs are criminalised by drug prohibition (Rolles, Kushlik and Jay 2004, p. 10). In the United Kingdom and the

[29] The testing was conducted as a self-report survey in conjunction with voluntary urinalysis. Substances tested included benzodiazepines, cannabis, cocaine, heroin, amphetamines, MDMA (Ecstasy) and other opiates.

United States the majority of those criminalised for drugs are impoverished and predominantly black (Rolles, Kushlik and Jay 2004, p. 10). In Australia, Indigenous people are vastly over-represented within the criminal justice system. This is partially explained by their visibility in rural and urban centres which brings them to the attention of police. It is also a consequence of colonial processes which have resulted in their dislocation from their land, and their social and economic exclusion which frequently leaves them unemployed, homeless and in poor health (Hogg and Carrington 2006; Reynolds 1989). In 2010, the Indigenous imprisonment rate was 14 times higher than the non-Indigenous prison rate (Australian Bureau of Statistics 2011), largely on account of a growth of punitive approaches to law and order (Cunneen 2008). The policing and incarceration of Indigenous people will be explored further in Chapters Five and Six using interview data of service providers and young Aboriginal people who use drugs.

Drug treatment or prison?

Extra-judicial functions

Legal sanctions on drug use do not simply aim to punish drug users, but include a range of extra-judicial functions to bring drug offenders into rehabilitation, treatments, or programs within prisons and in the community. According to Seddon (2006), Western nations use the criminal justice system as a means to coerce drug users into treatment. The rationale for coerced drug treatment is essentially to address drug related crime and therefore hinges on the premise of a strong causal link between drug addiction and crime, and the unproven assumption that treatment effectively reduces drug related crime (Seddon 2007a, p. 270). It has also been argued that the need for drug treatment is underpinned by the idea that drug dependence is a health disorder that occurs in individuals with pre-existing psycho-biological vulnerabilities, and therefore punishment alone is an inappropriate response (Chandler et al. 2009; United Nations Office on Drugs and Crime 2010). It is on this basis that the United Nations Office on Drugs and Crime (UNODC) (2010) suggests that treatment as an alternative to criminal justice sanctions should be available as an opportunity to drug dependent individuals for assistance and rehabilitation.

Mandatory treatment has been a topic of wide debate among academics and policy makers, focusing primarily on whether coerced treatment is effective and whether the element of lack of choice is an ethical breach of an individual's human rights (Marlowe et al. 1996; Pritchard, Mugavin and Swan 2007; Seddon 2007; Hall and Lucke 2010). Mandated treatment for drug offenders in Australia is relatively new (Bull 2003), particularly in comparison to the United States where the first compulsory treatment program, the California Civil Addict Program, was established in 1961 (Anglin and Hser 1990, p. 398). In Australia, programs are legally mandated at various stages of the criminal justice system process, either as an alternative to prison, or following release from prison or to assist the court to make a decision regarding sentencing (Pritchard, Mugavin and Swan 2007, p. 31). Offenders who do not comply with mandated treatment will be sentenced through the courts, however some offenders may choose prison over mandatory treatment (Pritchard et al. 2007). It has been argued that coercive strategies are at odds with the neo-liberal notion of consumer choice. On the one hand offenders are rational calculators with the capacity to 'choose' to undergo treatment, yet at the same time they are viewed as 'addicted consumers' who lack the capacity to choose (Seddon 2007; Reith 2004; O'Malley 2004). Contemporary variations of the nineteenth century case of the Earl of Mar are evident in this neo-liberal treatment paradox.

Blurring the boundaries between freedom and imprisonment

Diversion programs were part of the decarceration movement of the 1960s that aimed to reduce prison populations by shifting offenders into community type options (Rose 1999b). Diversion became part of the functions of the criminal justice system during the 1960s and 1970s largely as a response to the labelling effects of punitive responses which were thought to produce profound negative effects, such as social exclusion and stigmatisation. Initially, diversionary programs were part of the 'rehabilitative ideal', based on scientific positivist research which found the aetiology of criminal behaviour lies in the pathology of the offender, and therefore 'therapy' and treatment through rehabilitation would affect positive change in the individual (Allen 1959, p. 226). By the 1970s, amid growing scepticism and with unregulated state powers to 'cure' individuals through treatments and issue indeterminate sentencing practices for the purposes of rehabilitation, the rehabilitative ideal was declared a counter-productive failure (Garland, 2001;

Hoffman, 2001). Following a return to retributive, punitive justice and subsequent critiques of punitive policies, in particular their impact on homeless populations and drug users, there has been a renewed interest in rehabilitation and diversionary programs[30] (Goetz and Mitchell 2006, p. 478).

Drug diversion programs are a form of decriminalisation that, according to Garland (2001, p. 19), allow for the conservation of more expensive crime control resources for the most serious offences. The programs are intended to provide offenders with the opportunity to address their drug use while minimising their involvement in the criminal justice system (Roberts and Indermaur 2006). Diversion is based on an assumption that diversionary interventions are more effective than punitive strategies in achieving behavioural change (Bull 2010; 2003). The initiatives aim to reduce harm by diverting offenders from the court, hence reducing the stigmatisation and potentially harmful impacts of court processes on the individual, particularly young people. Diversionary strategies in Australia include early intervention, education and the diversion of drug offenders by police to compulsory counselling and treatment (Council of Australian Governments 9 April 1999).

In spite of the aim to reduce harm to the individual, Clancey and Howard (2006, p. 380) argue that some diversionary initiatives, which have been adopted under the banner of criminal justice drug treatment, represent considerable intrusion into the lives of drug users. For example, drug users may be ordered to undergo coercive treatment, urinalysis, official recording of personal information, judicial supervision, and intensive case management. In addition, a raft of 'alternatives' to imprisonment such as probation, community service orders, mediation/conferencing and police cautions aim to provide informal intervention. Drug diversionary programs and 'prison alternatives' have been criticised for their 'net-widening' effect which brings an increased number of young people into contact with the criminal justice system for minor offences that would previously have been dealt with informally (Clancey and Howard 2006; Hughes and Ritter 2008; Carrington 2006; Bull 2003; Roberts and Indermaur 2006). There is limited evidence that diversionary programs reduce the

[30] Hoffman (2001, p. 276) argues that with regard to drugs, a revival of rehabilitation has taken on a "new strain of drug law neo-rehabilitationism", due to a belief that drug addiction is a special kind of disease.

use of 'harder' options such as incarceration, but rather supplement or expand existing options (Hughes and Ritter 2008; Clancey and Howard 2006). Where the diversion comprises a compulsory form of treatment, those who fail to comply may be returned to the criminal justice system (Hughes and Ritter 2008, p.5).

Young people in diversion programs may frequently find themselves being subjected to complicated treatment regimes, characterised by a tightly regulated regime of urine testing, compulsory program participation, probation reporting, restrictions on living arrangements, curfews and electronic monitoring. Ironically, although these mechanisms are designed to ensure 'compliance', the broad scope of the limitations greatly enhances the likelihood of non-compliance (Clancey and Howard 2006, p. 380). Cohen (1979) suggests that the blurring and uncertainties inherent in diversionary strategies beckon to a future of surveillance and control where punishment and intervention, some of which is at least equal to that of a maximum security prison, is disguised as a 'soft option'.

While drug diversion programs vary between Australian jurisdictions, in Queensland diversionary initiatives include the Police Diversion Program for Minor Drug Offences, which is an early intervention and prevention program for individuals who are arrested or questioned for a minor drug offence involving cannabis (Queensland Police 2012). Other programs in Australia include the Drug Court Program[31] (Hughes and Ritter 2008) and the Cannabis Cautioning Scheme which diverts minor cannabis offenders from the courts by allowing for juveniles possessing up to 30 grams of cannabis, to be cautioned under the *Young Offenders Act 1997* (Bull 2003, p. 2). The establishment of Youth Drug Courts around Australia was an attempt to divert young people on drug charges away from punishment and provide them with intervention, treatment and rehabilitation (Bull 2003; Dive et al. 2003; Eardley et al. 2004). According to Bull (2010), the role of drug court judges can be likened to that of a therapist as the traditional adversarial focus is shifted to an extra-judicial function of managing a treatment process (Bull 2010). Offenders are assessed according to a range of extra-judicial physiological, psychological and behavioural factors thought to be associated with illicit drug use (Bull 2010, pp. 119-120). The

[31] The Drug Court Program was abolished in Queensland in 2012.

focus is on correction, rehabilitation and the development of self-regulatory mechanisms (Bull 2010, pp. 119-121). Diversion programs are discussed further in Chapter Five using interview data from service providers and other professionals, and in Chapter Six using data from interviews with young people.

Unintended consequences: perceptions of policy failure

The failure of the War on Drugs

Globally, drug commentators from academic, medical, legal and political fields have argued that punitive drug policies have failed to meet their objectives to reduce or prevent drug use (Bull 2003; MacCoun and Reuter 2001; Measham and Shiner 2009; Rolles, Kushlick and Jay 2004). In Australia there have been calls from former senior Australian politicians, academics, medical professionals and police to recognise the failure of 'get tough' approaches such as the War on Drugs, and ease prohibitions on drugs (Douglas and McDonald 2012). A Roundtable held at the University of Sydney in January 2012 responded to the United Nations Global Commission on Drug Policy which declared the 40 year War on Drugs a failure and called for an end to criminalisation of drug users (Global Commission on Drug Policy 2011). The Roundtable included former Australian Federal Police Commissioner Mick Palmer who commented that, in spite of increasingly sophisticated police efforts to control drug supply, their efforts have made little difference.

A proliferation of drug use and an explosion in production and trafficking of almost all types of drugs since the 1960s (Measham and Shiner 2009, p. 507) is evidence of Palmer's assertion that efforts to control drug supply have made little difference. The United Nations has expressed concerns that globally, drugs are now cheaper and more readily available than ever before and there have been substantial increases in drug use. Additionally, the production and use of illicit substances has become increasingly difficult to govern, and the use of pharmaceutical drugs, particularly opioids, has become more prevalent globally than any illegal drug except cannabis (United Nations 2012b, p. 81). This is to some extent due to the Internet, which has provided a medium for exchanging information about drugs and drug markets, and a site for the purchase of new substances not yet under international control (United Nations 2012b, p. 85). Nevertheless, in response to the Roundtable debate, the then

Australian Prime Minister Julia Gillard stated that policing of illicit drugs will not be eased and tough policing is necessary to "prevent the devastating consequences of drug use"[32] (Mark Metherell *Sydney Morning Herald* 3 April 2012).

Political constraints

Acknowledgement of the failure of the criminal justice system to reduce the supply and use of illicit drugs has been a topic of debate since the late 1970s. Similar concerns were noted in both the *Australian Royal Commission of Inquiry into Drugs* (1980) and the *Royal Commission into the Non-Medical Use of Drugs South Australia* (1978). However, Commissioner Justice Williams, heading the *Australian Royal Commission of Inquiry into Drugs,* commented that although the failure of the criminal justice approach was expensive and ineffective, with collaborative law enforcement efforts and a national approach a much better result could be achieved. In 1997, the Howard Government launched its national *Get Tough on Drugs Strategy to* increase law enforcement activities and increase rehabilitation and preventative approaches to reduce the demand for drugs. Douglas and McDonald (2012) argue that, while there has been an increase in drug seizures and convictions for drugs since 1997, there is no evidence that Justice Williams' ambition for a national policy, or John Howard's 'get tough' strategy has resulted in a reduction in the supply or use of illicit drugs (Douglas and McDonald 2012). Thus, according to Hay (2004, p. 505), the success of political ideas often relies on their ability to become institutionalised and embedded norms in policy making. When faced with policy failures policy-makers may strive to resolve contradictions within the confines of the existing framework, but they are often reluctant to concede the need to revise policy. In a report on US drug policy in 2001, the National Research Council Committee on Data and Research for Policy on Illegal Drugs expressed concerns about this reluctance to revise policy, concluding that: "It is unconscionable for this country to continue to carry out a public policy of this magnitude and cost without any way of knowing whether and to what extent it is having the desired effect" (Manski 2003, p. 543). Chapters Five and Six of this thesis seek to understand the scientific and political

[32] Perhaps the comment of former Australian Labor Minister for Health Neal Blewett in 1987, that "sensible and pragmatic politicians do not involve themselves … with drug issues … Drug problems … values … the definition of drugs … are all matters of dispute productive of controversy" (Blewett 1988, p. 191) is relevant to understanding Julia Gillard's comments.

rationalities that underpin drug treatments and law enforcement responses to illicit drug use. Chapter Five will further explore perceptions of failure of government and continued efforts to govern in spite of this failure.

Conclusion

This chapter has traced developments in public health and drug law enforcement policies from the 1960s, and the changes in drug use and drug cultures that accompanied these policy developments. The formation of drug subcultures during the 1960s accompanied an enormous growth in wealth, a population boom of young people aged 15 to 24 years, and the availability of an increasingly diverse array of recreational drugs. This marked the beginning of a new set of biopolitical problems to be governed, particularly concerns of a health epidemic resulting from injecting drug use and shared living arrangements among bohemian subcultures. It was during this period that drug users came to be conceived as potentially dangerous disease-carrying subcultural subjects. At the same time, there were considerable developments in psychiatry with a particular focus on the treatment of individuals unable to control their drug use. Concerns about drug related crime from the 1960s resulted in increasingly punitive approaches to drug use and a welding of rehabilitative and drug treatment programs with criminal justice sanctions.

Developments in public health from the 1960s are a legacy of the research conducted by Jerome Jaffe during President Nixon's period in office. During the 1960s there were considerable developments in drug treatments, in particular drug maintenance therapies and the emergence of harm reduction policies. Harm reduction went through significant changes following the HIV/AIDS epidemic of the 1980s and led to perceptions of injecting drug use as a contagious threat of epidemic proportions. This justified the need for biopolitical management of drug users through public health interventions. Drug users were brought into services, partially through methadone maintenance programs, but essentially to be counselled in harm reductionist techniques of safe injecting practices. Contemporary harm reduction approaches encompass supply reduction through law enforcement, demand reduction through rehabilitative and abstinence strategies, and harm reduction by reducing the risks associated with drug use. The apolitical approach of harm reduction has been

widely criticised for being antithetical, on the one hand taking a value-neutral approach to harmful drug prohibition, while on the other hand claiming to reduce harm through promoting safe drug use. This, in effect, transfers responsibility from governments to individuals, for harms caused by social, legal and economic factors. In this way, harm reduction is a neo-liberal risk management technology that makes drug users responsible for managing their own risk.

Finally, this chapter has explored political debates and controversies surrounding the 'drug problem', and perceptions of the failure of law enforcement efforts to achieve their objectives to reduce drug supply or demand. The developments in public health, medicine, law and policy investigated in this chapter will be illustrated with the use of interview data in Chapter Five and Chapter Six. The various types of drug use discussed in this chapter and their accompanying representations of drug users form the basis of Chapter Six. The following chapter outlines the methodological approach taken in this research project.

CHAPTER FOUR: RESEARCH METHODOLOGY

The previous chapters outlined some of the key historical, social and political contingencies that made drugs a contemporary problem for Western societies. This chapter provides an overview of Michel Foucault's concept of governmentality as a framework for locating the history of the 'drug problem' within the 'biopolitical age'. Biopolitics was concerned with the health and liberty of citizens, and was characterised by the development of science and medicine, and the emergence of new forms of regulation and surveillance for managing populations.

The concept of governmentality in this thesis allows for an analysis of the contemporary 'drug problem' through specific forms of problematisation since the nineteenth century that have emerged at the intersection of social, political and technological shifts. The chapter also contextualises the governmentality perspective within the research aims and questions, the research approach and the methods. The final part of the chapter describes the development of the research including data collection, sampling and participants, interviewing techniques, data analysis, transcription and the coding used in the thematic analysis of the data.

Foucault's Concept of Governmentality

A biopolitical problem of population

From modernist sovereignty to the 'art' of government

In his essay on governmentality, Foucault (1991a, pp. 87-88) explains that the problem of government arose during the sixteenth century at the interface of the breakdown of feudal structures which led to the establishment of the centralised state, and the religious dissidence that accompanied the Reformation. With a subsequent shift in the role of the state, the problem of government came to be one of how to be ruled, by whom, and by what methods (Foucault 1991a, p. 88). No longer concerned with preserving modernist sovereign authority, in the late sixteenth and early seventeenth centuries the state took as its object the 'art' of government—the art of exercising power to manage populations and the economy. Foucault (1991a) explains that this was, in a positive sense, governance according to rational principles

which are intrinsic to the state, yet not derived solely from natural or divine laws or principles of wisdom or prudence (Foucault 1991a, pp. 96-97). These changes marked the beginning of an era of the biopolitical age, which is concerned with forms of power exercised over living beings as members of a population, and the interconnection between individual conduct and national policy and power (Gordon 1991, pp. 4-5). The concern with specific problems of the population during the mid eighteenth century was fundamentally a concern with the welfare of the population, improvement of its health, increases in its wealth and longevity. Foucault explains this shift as 'the birth of a new art', using a range of new tactics and techniques to govern effectively, where the population is the subject of needs and aspirations, and the object of government (Foucault 1991a, p. 88). It is in this historical and political context that Foucault (1991a, p. 87) described governmentality as the primary locus of the emergence of a 'set of problems specific to the issue of population'. Governmentality is concerned with how to govern (Gordon 1991, p. 7) and is a way of problematising life and acting with different types of authority to ensure the wellbeing of a population (Rose 1993, p. 288).

Problematising populations

After the eighteenth century a religious framework of rules was, in part, replaced by a medical approach and a juridical framework (Foucault 1984a, p. 357). Certain persons, things or forms of conduct came to be seen as problematic according to criteria such as institutional norms, military requirements and legal regulations. This problematisation of the population produced a series of problems about the governability of individuals and populations, the focus of which was how to govern in relation to interventions such as health, criminality, pathology and psychiatry. In the *Birth of Biopolitics* Foucault (2008b) analysed the problematisation of populations as a rationalisation of problems presented to governments by the characteristics of human beings, such as health, sanitation, birth rate, longevity, race, etc. In order to manage these problems a range of new forms of surveillance, regulation, analysis, intervention and diverse techniques were developed during the late eighteenth century (Rose 1996c; O'Farrell 2005).

According to Rose (1999a), problems are defined as such by authorities, in relation to particular moral, political, economic, geopolitical or juridical concerns, or within

institutions such as the courts, armies, schools, prisons and so on. Foucault (1978; 1977a) described the development of medicine and law in the nineteenth century as power that formed micro-powers concerned with the body. These micro-powers involved surveillance of populations and the quantification of social behaviour, the object of which was the production of a normative, healthy population. Cultivation of physical wellbeing and optimum longevity of the population emerged as an essential objective of political power, and deviant populations were brought into conformity with a constructed norm and as normal subjects of government (Foucault 1980a; Hacking 1991). Foucault explained that medicine was underpinned by biopolitical objectives to manage population health and wellbeing:

> … a politico-medical hold on a population hedged in by a whole series of prescriptions relating not only to disease but to general forms of existence and behaviour (food and drink, sexuality and fecundity, clothing and the layout of living space). (Foucault 1980a, p. 176)

Problematisation is an important element of Foucault's concept of governmentality which makes possible an understanding of the interaction between power and government. Problematisation of particular forms of social behaviour, according to Rose and Miller (1992, pp. 175-176), is related to the exercise of power, the moral justifications for particular ways of exercising power by authorities, and the objects and limits of politics. Problematisations then, are consistent with the objectives of authorities and are in accordance with governmental rationalities (Rose and Miller 1992). Rationalities of government are systems of thinking about government in terms of practices, such as the activities of government, who can govern, and who is governed (Gordon 1991, p. 3). These are supported by governmental technologies, such as programs, calculations, apparatuses, documents and procedures, which are referred to by Foucault as 'techniques of power' or of 'power/knowledge'. Technologies are designed to observe, regulate, monitor and shape the behaviour of individuals within social and economic institutions to facilitate governmental ambitions (Gordon 1991; Rose and Miller 1992). There are interconnected continuities between different forms of government at the level of interpersonal relations, institutions and political government, and between forms of government existing within micro-settings, such as the family or school (Burchell 1993, p. 267). Hence, government is not approached as a uniform set of institutions, nor as a set of

political or constitutional principles, rather according to Dean and Hindess (1998) government can be conceived as:

> … an inventive, strategic, technical and artful set of 'assemblages' fashioned from diverse elements, put together in ... specific ways, and rationalised in relation to specific governmental objectives and goals. (Dean and Hindess 1998, p. 8)

Government from this perspective is an interaction of networks of inter-dependencies that exist at the interplay of political rationalisation and governmental technologies; these connect the lives of individuals, groups and organisations to the aspirations of authorities (Rose and Miller 1992, pp. 175-176).

Disciplinary power and normalisation

According to Foucault (1977a, p. 222), a regime can make it possible for collective will to form the fundamental authority of sovereignty. However, since the nineteenth century, disciplines such as science and law have provided a guarantee of the submission of forces and bodies. This has occurred, not through the disciplines themselves, but by a regulatory framework of normalisation that is external to disciplines or sovereign will, but ensures the operation of disciplinary power (Foucault 1980b, p. 106). Disciplinary power is exercised by means of continuous surveillance over humans and their operations, which Foucault refers to as disciplinary normalisations (Foucault 1980b, p. 104). Surveillance is enabled through therapeutic or preventative techniques such as therapy, correction, care or punishment (Castel 1991). During the nineteenth century, the disciplinary technology of the panopticon was used as a mechanism for the efficient surveillance of prisoners and the imposition of its own standard of normalisation (Dreyfus and Rabinow 1982, p. 194). Based on Jeremy Bentham's panopticon, Foucault's notion of panopticism in his history of the penitentiary is a form of surveillance; not the sort that requires a human presence, but rather an observing gaze with the intention of preventing problems in the population such as illness, abnormality, deviant behaviour and so on (Castel 1991).

Normalisation then does not refer to conforming populations to a constructed norm, but rather to the power of scientific truth and expert authorities to effect

normalisation through technologies of government (Rose 1999a; Donzelot 1979; Dreyfus and Rabinow 1982). The norm in this sense is the basis for the exercise and legitimisation of power. This is a positive form of power that operates through techniques of intervention and transformation to normalise populations. Unlike accounts of power as essentially negative, prohibitive and repressive, Foucault (1999) proposes that power functions through knowledge; it is productive and normalising, and repression results only as a secondary effect of productive mechanisms (p. 52). Disciplinary power lies in an array of technical innovations and practical strategies and technologies of normalisation, which humans themselves help to invent, and which they act upon to achieve certain ends (Rose 1999a, p. xxi); hence humans participate in their own processes of normalisation. While authorities and their scientific expertise actively shape and transform objects, techniques and ends of power, this is not achieved simply through techniques of regulation, or manipulating humans to achieve compliance to a social order, but also through individuals (Rose 1999a, p. xiii). Disciplinary power then is not reductionist but is a contingent and normalising form of power that produces autonomous, self-directing citizens.

Governing oneself and others

Governmentality is not simply concerned with governing through authority or domination by the power of the state, but incorporates practical as well as positive concerns, such as the ways in which individuals govern themselves. In a Foucaultian sense, government is complex and multifaceted and intrudes into all aspects of life. It encompasses not only the attempts by the state to regulate the conduct of populations, groups and organisations, but also the diverse ways in which individuals manage their own behaviour (Dean and Hindess 1998, pp. 2-3). Foucault (1994b, p. 147) describes self-governance in terms of an interaction between technologies of domination of others and of the self. This interaction involves individuals shaping and regulating their conduct in various social forms that are consistent with the objectives of governing authorities (Foucault 2008a). From this perspective, government of oneself and others is a set of multifarious activities, guided by techniques and procedures that govern human conduct in accordance with certain principles or goals (Foucault 2008a; 1991a; 1980). Government then involves the government of oneself and others through various practical techniques, goals,

programs and strategies, which support the objectives of the authority of the state (Rose 1993, p. 288). From this perspective, government is not simply 'top down' authority over individuals, but includes the ways in which individuals shape and regulate themselves in terms of social norms, to become what is defined as a civilised member of society. Self-governing takes place within sites such as the school, the family and various institutions such as medicine and law, which create individuals who do not need to be governed by others but will govern and regulate themselves (Rose 1993, p. 291).

Power, knowledge, truth

Governmentality helps explain the reciprocal relationship between power, knowledge, truth and production of the self, and how particular forms of knowledge have been rendered truthful at particular historical moments. The notion of truth is linked with knowledge and dominant discourses of governing authorities, and in the power, knowledge, truth relationship the regime determines what is formulated as true or false (Foucault 1991b, p. 79). Foucault's interest in truth was about what counts as truth at a given time and what the conditions are that allow the formation of a 'regime of truth'. He uses the term 'regime of truth' to describe the relationship between truth and the systems of power that sustain it; power induces truth and in turn configures it. Truth is then, already power; it is not a question of which truth is correct, but rather how the rules work in a particular society that distinguishes true representations from false ones (Foucault cited in Treichler 1999, p. 139).

According to Foucault (1991a) the production of truth is infused with relations of power, and shaped by social institutions such as prisons, clinics and social institutions that establish norms and values to determine what is valid as truth. Borrowing from Rose (1999b, pp. 9, 22) these truths are 'veridical discourses', centred around scientific norms, moral rhetorics and ethical vocabularies, and always open to critical correction and translation. Rose discusses veridical discourses as positive knowledges and expertises of truth that have played a key role in rationalities of government since the nineteenth century. Veridical discourses have produced governable spaces, such as the economy, factory and the population. These spaces have made up governable subjects and accorded legitimacy to experts to

exercise authority over human conduct. Legitimacy is claimed on the basis that experts can deal truthfully with the problems of human existence according to knowledge of the nature of individuals (Rose 1999a, pp. xxii- xxiii).

According to Foucault (1980c, 1977a) power is not owned, but is exercised; each society has a regime of truth which it accepts and makes function as true (Foucault 1980e, p. 131). It is dispersed, and is integrated and exercised, with knowledge, so that power continuously creates knowledge and, conversely, knowledge constantly induces the effects of power (Foucault 1980e, pp. 27-28, 52). Foucault was concerned with how knowledge determines truth and how individuals govern themselves according to these truths. This is illustrated in his comment "… my problem is to see how men govern (themselves and others) by the production of truth …" (Foucault 1991b, p. 79). Truth cannot exist outside power, nor is it to be discovered and accepted, but rather, as Foucault explains, truth is:

> … the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true … it's … a battle about the status of truth and the economic and political role it plays. (Foucault 1980e, p. 132)

What becomes truth, then, is that which can become associated with desired effects and consequences in the various forms that it helps create (Rose 1999a, p. xvi). Once certain truths have become established and certain phenomena made salient, they can be investigated, explored, classified and analysed. These truths become realities about the world, closing off possibilities for the production of other realities and subsequently, for other research and investigation (Rose 1999a, p. xvi). There are different ways in which individuals develop knowledge about themselves, such as through economics, biology, psychiatry, medicine, law, criminology and penology (Rose 1999a). Foucault refers to the development of knowledge as 'truth games' that are related to technologies of domination which constitute certain modes of training and modification of individuals.

Liberal rationalities

Biopolitical objectives

The biopolitical problems of population cannot be dissociated from the framework of political rationality and liberalism (Foucault 1994c, p. 202). Foucault's view of liberalism differs from 'classical'[33] political doctrine, theory or ideology concerned with individual freedom and liberty against extreme forms of state control (Foucault 1994c, pp. 202-203; Hindess 1996, p. 124-125). Foucault discusses liberalism as political rationality of government, as a way of thinking, reasoning, and doing things oriented toward objectives and regulating itself through sustained reflection (Foucault 1994c; Hindess 1996; Garland 1999). In Foucault's view, liberalism is a principle and a method of rationalising the exercise of government; a rationalisation that aims to secure the conditions under which social and economic processes will work effectively with limited government, and with maximum economy as its objective (Foucault 1994c, pp. 202-203). This requires forms of regulation to permit and facilitate natural regulation with the objective to set in place:

> … mechanisms … of state intervention whose function is to assure the security of ... economic processes and the intrinsic processes of population: this is what becomes the basic objective of governmental rationality … liberty is … now the indispensable element of governmental rationality itself. (Foucault quoted in Gordon 1991, pp. 19-20)

Rose and Miller's (1992) explanation of the concept of governmentality presents three principles for an analysis of liberal rationalities. The first of these is that political rationalities have a moral form, articulating different types of authoritative powers and duties according to a proper distribution of tasks and actions, such as political, spiritual, military, pedagogic or familial. These powers are directed to ideals such as freedom, justice, equality, mutual responsibility, citizenship, common sense, economic efficiency, prosperity, rationality and so on. Secondly, epistemology is a political rationality that is concerned with the nature of things governed—society, the nation, population and the economy. These groups constitute populations

[33] Classical liberalism understands liberalism as the protection of individual liberty by allowing the state to be sufficiently powerful to secure the liberty of its subjects (for example, through legal and military protection), while limiting government (for example, from the abuse of power) in the interests of individual liberty.

to be managed, resources to be exploited, legal subjects with rights and children to be educated. Thirdly, political rationalities are constituted within a distinctive idiom or political discourse, which renders reality thinkable and truthful to meet political objectives (Rose and Miller 1992, p. 179).

Liberal rationalities then, comprise morals, knowledge and political discourses, which are constituted of particular techniques, procedures, regulations and laws to enable its function in accordance with the production of health, wealth and well-being of the population. These techniques exercise public and private forms of power which facilitate the moralisation and normalisation of the population. This includes self-governing techniques such as parental roles and workplace relations that create the conditions for efficient social and economic activity, and public ends for the good of society as a whole. Liberal governance also involves and requires governed individuals to exercise their regulated freedom in appropriate ways through the acquisition and development of habits of hygiene, sobriety, fidelity, responsibility and self-improvement (Burchell 1993, pp. 272-273). According to Rose (1999a), political, moral and organisational authority can be exercised in ways that fit with liberal notions of individual freedom, autonomy and choice, and ideas about liberal democratic limits on the scope of legitimate political intervention (Rose 1999a, p. 7). Liberal rationality enables individuals to make free choices to pursue the long-term objectives of government, and this facilitates the working of governmental power through the behaviour of free citizens (Hindess 1996, p. 125). Rose refers to this as 'government through freedom' whereby the citizen as consumer becomes an active agent in the regulation of professional expertise (Rose 1999a, p. xxiii).

Scientific disciplines and expertise play a key role in contemporary forms of political power to enable 'governable subjects' to emerge from liberal democratic governance. Rose (1999a, p. xvii) analyses how humans have been understood within social processes and developments, how such understandings have been shaped by ways of thinking and acting, what sorts of techniques for governing humans have been linked to these understandings, and what consequences resulted. The self, therefore, is not a product of social, economic, political or cultural relations, but is complex and formed at the juncture of a whole variety of techniques and practices, with no single point of origin or unification. It is through processes within the habitat of everyday living,

such as workplaces, libraries, sporting facilities, hospitals, churches and homes, that the self is formed (Rose 1999a, p. xx-xxi).

In Foucault's view, the exercise of power involves a degree of freedom for its subjects, and the liberal rationality of government recognises that the long-term objectives of government are best pursued through the free decisions of individuals, rather than through coercive strategies such as police regulation and control (Hindess 1996, p. 125). Therefore, the effective working of government depends on its ability to secure the conditions for free persons to pursue their own objectives (Hindess 1996, p. 128). At the same time, the working of governmental power through the behaviour of free citizens and the self-governance of citizens as agents of free, responsible choice, secures the conditions for optimum economic performance and minimum socio-political cost (Burchell 1993, p. 273). Paradoxically, while the conduct of government is rationalised and justified in terms of liberal principles of economy, there are no universally agreed criteria for gauging the success of government in this respect (Burchell 1993, p. 273).

From welfarism to neo-liberalism

During the first part of the twentieth century, most Western societies became 'welfare states', characterised by strategies to ensure high levels of employment, economic growth, social security, health and housing through the tax system and fiscal planning, and the development of extensive bureaucracies and social administration systems (Rose and Miller 1992, p. 191). Under welfarism, there was an expansion of statistical, mathematical and scientific expertise, shaping new problems of the population and crystallising relationships between experts and their forms of knowledge and the state (Rose 1991, 1999a, pp. 217-243; Hacking 1981, 1991).

In response to these problems, the new welfare mode of governance concerned itself with managing the economic, social and personal lives of individuals. Rose and Miller (1992, p. 192) explain that welfarism was characterised by a political rationality which sought to secure social and economic objectives by linking an array of networks intended to know, program, and transform the social environment. The rationality of welfarism was concerned with specific problematisations and the

normalisation of the population through the governance of health, delinquency, the problem family and social integration. Courts, prisons, organisations, schools and clinics and their diverse programs and techniques sought to make calculable the activities of individuals, the duties of whom would be relayed back to them through the network in the form of norms, standards and constraints (Rose and Miller 1992, pp. 193-194). By the 1970s, with a rapidly expanding health system, an unmanageable demand for state funded medical services and a belief that the welfare state had a morally damaging effect on citizens by encouraging welfare dependence, welfarism gave way to a new 'neo-liberal' mode of government (Rose and Miller 1992, pp. 195-198).

While there are many philosophical similarities between liberalism and neo-liberalism, such as responsibility, self-government, free choice and maximum economy, the distinctiveness of neo-liberalism lies in its political practice (Kendall 2003a; 2003b). Neo-liberalism can be understood as a distinct form of government with political, economic and cultural components, which has sought to replace a perceived culture of welfare dependence with individual entrepreneurship (Kendall 2003a, p. 6). The economic rationalist approach of neo-liberalism replaces political responsibilities where possible, with commodified forms and regulation according to market principles. Perceived passive dependence is replaced by individual autonomy whereby individuals take responsibility for making their own decisions and calculating outcomes to maximise their own advantage (Rose and Miller 1992, p. 198; Hindess 1996, p. 13). Neo-liberalism has not simply provided an alternative to welfarism, but rather, has forged a new relationship between expertise and politics. This has been the establishment of distant relations of control between political decisions and sites of governance, such as schools, hospitals and firms with enforced state-sponsored inspection of zones, such as education and health (Rose 1993, p. 295; Kendall 2003b).

While technologies of welfarism accorded power to experts who possessed knowledge and 'spoke truths' to enable authority, neo-liberalism rendered the authority of experts governable through operable techniques such as monetarisation, marketisation, enhancement of consumer powers, financial accountability and audit (Rose 1993, p. 295). Truth is no longer assigned solely to the knowledge of experts,

nor are relations between citizens and experts governed simply by authoritative regulatory powers. Rather, social and economic institutions such as housing agencies, health services, social welfare services and so on are consumer choices, and autonomous purchasers can buy choices from a range of options (Rose 1993, p. 296). Neo-liberal governance features the continued intervention of state apparatuses, yet government takes a back seat to market forces and shifts the responsibility for managing social risks such as illness, unemployment, poverty, etc., to an individual problem of 'self-care' (Lemke 2001, p. 201; Kendall 2003a, p. 7; Gordon 1991, p. 44). Gordon (1991) explains that this 'care of the self' is evident in the idea that one's life is the enterprise of oneself, of the continuous business of living and improving, which manifests as a range of techniques of the self that are attuned to the notion of self-awareness and self-realisation. The individual life project can be understood as a part of the "managerialisation of personal identity and personal relations which accompanies the capitalization of the meaning of life" (p. 44).

Techniques of the rational individual

Burchell (1993) explains that neo-liberalism is characterised by its promotion of an enterprise culture and a style of government that encompasses all forms of conduct—the conduct of organisations seen as being non-economic, the conduct of government and the conduct of individuals themselves. The forms of action that give effect to neo-liberal governance are constructed for schools, hospitals, clinics, prisons and other sites of social activity. These forms are made effective by the adoption by those governed of certain entrepreneurial forms of practical relationship to themselves. Individuals therefore assume active responsibility for carrying out activities, and for their outcomes, in accordance with resolving issues that were previously the responsibility of governmental authorities. This relationship between government and the governed renders individuals responsible for freely and rationally conducting their lives (p. 276). Hence, there is a reorganisation of government techniques as the withdrawal of the state reverses relations of authority and the responsibility for regulation is shifted to responsible and rational individuals (Lemke 2001, pp. 201-202).

The neo-liberal responsible individual is synonymous with a moral and economic-rational individual who is self-determined and assesses the costs and benefits of actions and, hence, is solely responsible for their outcomes (Lemke 2001, p. 201). In contrast to welfarism, which attempted to address unemployment, substance abuse, criminality, homeless, etc., as problems for the state, neo-liberalism constructs these issues as individual through responsibilisation of the subject. The social domain is therefore rendered economic as welfare services are linked to the individual responsibility and self-care. Autonomy becomes a technique of power as individuals and institutions optimise their entrepreneurial capacity in accordance with political-economic objectives (Lemke 2001, p. 202).

Research Aims and Questions

The research explores how drug use among young people is governed in contemporary Australian society and how the governance of drugs through law, public health and medicine intersects with self-governance to shape young people's drug use practices. Young people are the focus of the investigation because, as the literature review has identified, their drug use tends to be more diverse than drug use among older people. Hence, young people's drug use is potentially more interesting and provides richer material for the research. The diversity of their drug use includes the part-time use of party drugs, however they also enjoy a range of other chemical substances such as amphetamines, prescription drugs and heroin. According to the literature review, not all drugs are equal in terms of perceptions of problematic drug use, nor are they all governed in the same ways; 'recreational' party drugs are perceived and managed quite differently to drugs of dependency or addiction.

The foundations of the drug problem outlined in Chapter Two and Chapter Three, enable an investigation of the historical, social and political contingencies of 'problematic drug use' which have shaped contemporary responses to the drug problem. These contingencies are interwoven with the analysis of empirical data in Chapter Five and Chapter Six to illustrate how various forms of governance operate, the strategies and rationalities they use to govern illicit drug use, and the 'truths' they produce about drugs and drug users. Building on existing drug literature, the use of empirical data in Chapter Six seeks to understand how young people form drug user

subjectivities and particular drug use practices within external forms of authority and their own self-governance. These practices are conceptualised in terms of Foucault's 'practices of the self'. The following two research questions are concerned with the ways in which drug users are governed, and self-govern their drug use to form a drug user self:

1. What are the technologies that govern drug use, and how are these made possible through contemporary knowledge, truths and political rationalities?

2. How do drug users form a drug user self through an interaction of authoritative governance and their own drug use practices?

Foucault in the Research

Governmentality as method

Problematising drugs and drug use

Rather than providing methodological tools for research, governmentality is an approach that encompasses a series of phenomena (Kendall and Wickham 2004, pp. 142-143). Foucault's approach is empirical and historical rather than theoretical (Kendall 2011) and it has been suggested that there is no particular 'Foucaultian method' because Foucault was so 'unmethodological' (Kendall and Wickham 1999, p. viii). Nevertheless, according to Kendall and Wickham (1999), it is possible to identify some themes for research in Foucault's approach. Kendall and Wickham (2004) suggest that governmentality is a kind of meta-analysis which focuses on the everyday practices of liberal government. According to Seddon (2010), the three historical frameworks of governmentality—liberalism, welfarism and neo-liberalism—provide a useful, heuristic device for interpreting empirical data. This approach to history is not one of identifying, momentous changes or epochs which erase older ways, or consign them to history. Rather, it seeks to identify new, complex developments that take place alongside old arrangements, at the intersection of social, political, discursive and technological shifts (Rose 1999b, p. 173).

The focus of the governmentality approach, then, is to capture multiple practices, techniques and forms of knowledge, which tend to be overlooked in historical analyses which focus on government as simply political institutions or political thought (Dean and Hindess 1998, p. 8). In this process, there is a continuous forming and reforming of the social realm and a constant process of problematisation and solutions (Rose 1999b; Garland 1985). In an interview with Paul Rabinow, Foucault (1984a) spoke about the history of thought as problematisations—a work of thought, and a study of practices that constitute various truths, such as scientific knowledge or political analysis. For Foucault, problematisation is a way of creating the conditions in which possible responses can be given to a problem, and an analysis of problematisation deconstructs the different solutions to problems and how these result from a specific form of problematisation (Foucault 1994a, p. 24). The governmentality concept in this research provides a means for deconstructing the different contemporary solutions to drugs and drug use, and how these solutions are linked with the problematisation of specific forms of drug use. Following Foucault's approach, the research asks 'how' rather than 'why' and seeks to understand how drugs and drug users came to be a problem, rather than investigating solutions to a pre-given assumption of a drug problem (Kendall and Wickham 2004, p. 144).

Limitations of the governmentality approach

The governmentality approach in this research provides a framework for understanding relations of power and the practices of government, and how drug use has been made a problem in contemporary neo-liberal societies. However, it has been criticised for its failure to take into account the experiences of those who are governed (Lippert and Stenson 2010). In the context of crime, Garland (1990, p. 3) argues that this results in an inability to recognise important 'tragic' and futile aspects of crime and punishment. This amounts to a neglect of the 'real' due to the lack of empirical investigation of everyday life (Lippert and Stenson 2010). The current thesis, however, is not concerned solely with practices of government for its analysis (Lippert and Stenson 2010), nor does it omit empirical experiences of everyday life. Rather, it draws on Foucault's historical empirical work and his governmentality framework in order to trace the historical continuities between the nineteenth century problematisation of drugs and the contemporary governance of

drugs and drug users. This involves an analysis that is grounded in the everyday experiences of drug users in different social and cultural contexts.

Disrupting knowledge

History of the present

Latour and Woolgar (1986, p. 107) criticise professional historians who are all-knowing and all-seeing, and who produce a chronology of events to determine what 'really happened'. They argue that these historians are like gods, able to invent literary fictions of the past, possess knowledge of the future, survey settings in which they have never been involved, understand motives and judge what is good and bad. The non-determinist view of history favoured by Latour and Woolgar (1986) is also characteristic of Foucault's (1977a) work and is relevant to his use of history as a 'history of the present'.[34] A history of the present makes sense of the present while avoiding universalist concepts of rationality, and metanarratives of progress and reason (Dean 1994, p. 21). It is not a unity between past and present by attributing past causes to present conditions, but, rather, a history that disrupts and fragments the territory that has made possible all forms of expertise (Rose 1990). The current research is a history of the present in its use of historical resources that reflect the interconnections (Dean 1994), contingencies and nuances, which allow for a problematisation of drugs and drug users. Interdependencies between social, political and economic factors have determined which issues are made salient as drug 'problems' and what has become 'truth' about drugs.

Subverting the status quo

Foucault did not assume an external truth or reality upon which the social could be understood. He explained that universality and the notion of a timeless subject were fixed to the status quo and attached people to specific identities that could not be changed. For Foucault, the notion of continuity and universality is at the foundation of all thought and action, and how individuals make sense of the world (O'Farrell 2005, p. 110). Foucault, however, was committed to subverting the status quo by

[34]Foucault (1977a) commented that he would like to write a history of the prison with all its political nuances, not because he is interested in the past to explain the present, but to write the history of the present (p. 31).

constantly disrupting the idea of a 'correct' way of viewing social life (Kendall 2011). It is for this reason that Foucault (1984e) commented that knowledge is not made for understanding, it is made for cutting (p. 48). In this statement, he was suggesting that knowledge is not a truth that is produced by a continuous process of progression, but, rather, a process of discontinuities and disruptions. He explained that his work is the study of how people govern themselves and others by the production of truth, in the sense that truth and falsehood are made pertinent by historical analysis and political critique (Foucault 1991b, p. 79). His use of history, therefore, is not teleological in the sense that it is a way to understand how the present has emerged from the past. Rather, Foucault uses history to disrupt the status quo by showing that social life and problems are not the result of intention, destiny and design, but, rather, human error, illusion, accidents and struggles for power (O'Farrell 2005, p. 76).

The Research Approach

Doing drug research

Reproducing the subject

Rhodes and Moore (2001, p. 281) argue that the clandestine nature of many drug use behaviours and 'subcultures' has provided ideal material for researchers of 'hidden' lifestyles and populations. Many of these studies are directed at drug policy and the knowledge produced by them is influenced by research funding that is aimed either at preventing drug use or minimising the harms associated with it (Martin and Stenner 2004, p. 395). The policy and interventions prescribed by this type of research are typically founded on pre-conceived notions of particular characteristics of drug use and drug users (Agar 1997, p. 1168). This results in a dominant research focus on the 'pathology paradigm', which usually encompasses epidemiology, medicine and psychology (Moore 2002).

Research methodologies provide a framework for producing representations of drug use, yet it is not always clear how this framework influences the presentation of drug use in the research. Martin and Stenner (2004) consider that it is important to reflect upon the agenda of government that pervades social science research. This allows for

an awareness of how the framework influences the products of social science, recognition of its influence on the conduct of participants and subsequent reproduction of truths about social problems. Rose (1990, pp. 105-106) argues that the role of the social sciences in manufacturing knowledge of individuals and social life is used to make new sectors of reality thinkable and practicable. In this process, domains are realised, brought into existence through the languages that represent them, then analysed and diagnosed so that solutions to pre-given problems can be prescribed. Despite claims of acquiring new subject knowledge through social science research, the research becomes a selective process of bringing subjects into being by practices that claim to discover them, and the language used to describe them. Reality then, becomes that which is reproduced in the research process (Martin and Stenner, 2004: 397-398). This is described by Martin and Stenner (2004, p. 395) as producing and reproducing the pre-given drug user research subject in relation to certain 'truths'. Moore (2002, p. 19) suggests that greater diversity of views in drug research could shift conceptions of drug use and assist an understanding of drug users outside the pathology paradigm—as subjects that are produced through institutional practices and practices of the self.

Facts as reality

According to Foucault (1977a, pp. 27-28), power and knowledge coexist and are mutually interdependent. In drug research, the reproduction of the pre-given subject does not derive knowledge from the subject, but is a process of power-knowledge that determines the forms and domains for the knowledge. In this type of research, concepts such as addiction, dependence and drug problems are brought into existence as a domain to be governed (Martin and Stenner 2004, p. 398). From this perspective, the facts of drug use are made into a reality in policy, social institutions and so on. Drug problems, then, are part of a broader realm in which truths about drugs use form the basis of contemporary governance and translate into ways of monitoring, optimising and organising drug using individuals and populations (Vrecko 2010a, p. 62). When these truths become 'facts' about drug use, an awareness of their historical contingency and fabrication is forgotten and they come to be thought of as having a natural existence; these 'truths' are subsequently reproduced in research (Vrecko 2010a; Treichler 1999).

Challenging the rules

Avoiding methodological hegemony

The research uses a method proposed by Law (2004, p. 4) which is broader, looser, more generous, and in some ways different from many conventional understandings. Law (2004, p. 8) argues that efforts to understand populations or societies cannot be captured in prescribed methods of inquiry. While standard research methods are suitable for many studies, the normativities attached to them are not suited to all studies. According to Law (2004, p. 5) standard methods can claim methodological hegemony and constrain the research by placing rules on what must be seen or investigated. Underpinning standard methods of research is the idea that reality cannot properly be understood unless the rules are followed, and failure to do so will result in substandard, distorted or invalid knowledge (Law 2004, p. 5). This is due to the mutual constitutive relationship between knowledge and reality in which knowledge shapes the reality it seeks to understand and reality shapes knowledge (Latour 2004; p. 2005). According to Law (2004, p. 5), it is taken for granted that such self-fulfilling methods and rules are necessary for gathering and theorising data. The need for particular sets of methodological rules becomes naturalised, and this has profound implications for understanding the nature of research, and how research should be undertaken. It subsequently becomes taken for granted that social life is best understood through a set of fairly specific, determinate and identifiable processes.

Validity as truth

Research that is thought to be anecdotal[35] is said to lack 'validity' or 'truth'. If qualitative interviews have been conducted there may also be concern that the research lacks objectivity because the knowledge is produced through the interviewer rather than 'objectively' through scientific methods. Researchers generally try to safeguard against the risk of invalidity by using verification tests and comparisons known as triangulation,[36] with other data sources, usually quantitative data

[35] This is generally a criticism of qualitative research.
[36] It is argued that this type of comparison adds validity to the research by checking the consistency of data (Guba and Lincoln 1989; Patton 2002); hence validity sets the parameters for reliable, generalisable social research (Mischler 1990; Kvale 1995).

(Silverman 2010, p. 34). Some qualitative researchers, concerned with the incompatibility of validity to qualitative research, have either dismissed validity as an oppressive positivist concept, or have proposed alternative concepts of validity[37] (Kvale 1995; Cho and Trent 2006; Mischler 1990). Latour (2000, p. 116) critiques the notion of objectivity in the social sciences, suggesting that objectivity is unattainable when humans are the subjects of study. He argues that if social scientists want objectivity they should find subjects who can object to what is said about them and raise their own questions in their own terms. In a similar vein, Hammersley (1992, pp. 50-51) points out that all knowledge is differential and is acquired through subjective interpretation, and therefore it is not synonymous with absolute certainty. Postmodernist accounts however, tend to dismiss issues of reliability, validity and generalisation as a singular truth. From a postmodern perspective there are multiple truths that cannot be defined simply by juxtaposing them with non-truths (Kvale 1995, p. 21).

Foucault's method involves empirical and historical verification, and from a Foucaultian perspective the notion of validation in research involves assigning power to particular authorities to determine the truth of the research. The approach used in the current research aims to disrupt truths about drugs, and reconceptualise the contemporary governance of drugs as an interaction between truth, power and knowledge. The research does not seek to prove a hypothesis or validate truth claims, but rather to present versions of truths according to the experiences of interview respondents. These truths are translated through historical accounts of how drugs and drug use became a problem, and the relations of power that have defined the problem. For Foucault, the dilemma of researchers is not whether the research provides an authentic account of subjects or social phenomena, but rather how to conduct research that allows for an understanding of the interplay of power and subject. There is no presupposition of specific or identifiable processes of the social that are waiting to be 'discovered'. Nor does the research define categories or variables for investigation a priori on the basis of pre-formulated hypotheses and

[37] Alternative concepts of validity include concepts of trustworthiness to establish credibility, transferability, dependability and confirmability (Lincoln and Guba 1985; Mischler 1990; Cho and Trent 2006), and 'member checking' to enhance the credibility and objectivity of the research (Lincoln and Guba 1985).

theoretical frameworks, but rather concepts emerge from research data (Rhodes and Moore 2001, p. 287)[38]. Following Foucault, the research enables plural and competing interpretations of drug use (Rhodes and Moore 2001, p. 291) without the imposition of a singular 'truth' (Patton 2002; Martin and Stenner 2004, p. 396).

Including subjugated knowledges

This research attempts to disrupt the idea of a singular truth of drugs and drug users by including alternative truths. In *Two Lectures* Foucault (1980b, p. 82) suggests that 'subjugated knowledges' tend to be excluded in historical contents and subsequently overlooked. Subjugated knowledges may be those that have been disqualified as inadequate to constitute scientificity, and are therefore regarded as naïve, unqualified and low down on the hierarchy of knowledges, such as the delinquent, the psychiatric patient or the ill person. He also suggests that only those directly concerned can speak in a practical way on their own behalf (Foucault 1980b, p. 209). For Foucault (1980b, p. 50), the re-emergence of these low-ranking knowledges enables criticism and allows alternative truths to be infused into the field. Following Foucault, the current research approach includes subjugated knowledges of young people who use drugs, as they are regarded as experts of their experiences.

Ethnographic approach

Ethnography best describes the data collection phase and thematic analysis of this research, particularly the fieldwork involving interviews with young people who use drugs. Although ethnography does not have a well defined meaning, it is usually characterised by unstructured data collection and the generation of themes from research data, rather than thematic analysis using pre-existing categories (Hammersley and Atkinson 2007, p. 3). Broadly speaking, ethnography is defined as research that aims to understand another way of life from a native point of view, and may be an effective method for studying social activity such as drug use (Berg and Lune 2012, p. 196). Consistent with a Foucaultian approach, however, the research does not assume that cultures are static or pre-determined groups. Rather, it is

[38] The method followed in the research is consistent with definitions of inductive, qualitative research which is founded on the idea of the socially situated nature of action and the need to understand participants' definitions of a particular phenomenon or situation (Rhodes and Moore 2001, p. 280).

acknowledged that a culture is simultaneously a creation of the ethnographer and what is generated by members' interactions (Latour 2005, p. 168). An advantage of the ethnographic approach is that it allows for a perspective of relative messiness of practice by looking behind the official accounts of method to try to understand the often ragged ways in which research produces knowledge (Law 2004, pp. 18-19). The value of ethnography in the current research lies in its potential to include subjects who are directly related to the research topic, and allows scope for a critical perspective on the universality of scientific knowledge, and the transgression of the boundaries of closed theoretical and methodological systems (Tamboukou and Ball 2003, pp. 3-4). The need to match interview data with theory is transcended in the current research through the use of history combined with interview data, which allows interview data to be translated through a 'history of the present'.

Research Methods

Data collection

Participants

The aim of this study is to understand how young people's drug use practices interact with forms of governance. A review of the literature suggests that drug use varies considerably between different social groups, and 'middle class' drug users are governed quite differently from those who are unemployed, homeless or impoverished. In order to address the research aims and questions, data was collected, firstly, from drug service providers and other professionals directly involved in the governance of drugs and, secondly, from young people who use a diverse range of drugs in a variety of ways.

Service providers

Following ethics approval[39], purposive sampling[40] was used to recruit 15 service providers and other professionals in Brisbane and Sydney. Participants, comprising

[39] See Appendix A for details of ethics approval and issues of confidentiality for the research.
[40] Denzin and Lincoln (1994, p. 202) explain that purposive sampling seeks out groups, settings and individuals where the topic of study is most likely to occur. This is an ideal way to recruit specialised populations and select cases with a specific purpose and inclusion criteria in mind (Neuman 2006, p. 222).

five women and 10 men, one of whom identified as an Indigenous barrister, were involved in drug law enforcement, drug education and the delivery of medical care and drug services to young people. Informants included police, a legal professional, health professionals who provide treatment services, social workers and counsellors, workers from non-government organisations that administer needle syringe programs and other harm reduction strategies, and researchers and drug educators. Initial contact was made through a telephone call to potential interviewees. Those who expressed an interest in the research were sent a copy of the participant information sheet and consent form, and a copy of the interview schedule (see Appendix B and Appendix C). Clarification of the research was provided where required and a meeting was subsequently arranged for an interview. Table 1 provides a summary of informants recruited for interview according to their pseudonyms and roles:

Table 1. Service providers and other professionals interviewed for the research

Interviewee	Role in governing drug use
Ray, ex-police officer	Previously worked for the drug squad and undercover agent investigating drug markets.
Jim, police officer	Currently involved in international drug control.
Dr Stephen, medical doctor	Core patient group is drug users requiring pharmacotherapy treatment.
Dr Matthew, medical doctor	Treats patients with HIV/AIDS including intravenous drug users, in the community and in prisons.
Tom & Louise, drug intervention workers	Provide counselling, activities and interventions to young people, most of whom use drugs.
Jack, Indigenous barrister	Worked with young Aboriginal offenders in remote communities.
Rose, community development worker and injecting drug user/peer worker	Provides counselling and peer support to injecting drug users.
Ben, duty counsellor	Provides counselling and referrals for drug users.
Louise, needle syringe program worker	Provides clean injecting equipment and information about safe injecting practices and HIV/AIDS and hepatitis C to drug users.
Lee, communications and research coordinator	Provides research and networking to a non-government organisation and supports alcohol and other drug users and their families.
Bill, drug researcher, chemist and events coordinator	Organizes ‘Rave’ events; researches and publishes on chemical compounds of legal highs.
Rob & Sue, health education workers	Facilitate safe injecting practices and other harm reduction techniques.
Michael, drug researcher and education worker	Independent drug researcher and publisher of drug education.

Young people

Young people were recruited through purposive sampling and snowball sampling[41] from four different sources: a youth service, universities, participants' networks, and through an online drug discussion forum *Bluelight.*[42] The first cohort of young people recruited from the youth centre were initially contacted through the cooperation of staff at the centre who were provided with a copy of the participant information sheet and a copy of the interview schedule (see Appendix D and Appendix E). Staff subsequently identified young people suitable for interviews, and provided a room for confidential interviews. Students at universities were recruited through online and hard copy media releases distributed through university networks. The media releases outlined the background to the research, the research aims, the age cohort required for the research, and the researcher's contact details. When interested participants contacted the researcher they were sent copies of the participant information sheet and the interview schedule and an interview was arranged within the grounds of their university. Interviewees were asked to pass on research information and the researcher's contact details to anyone they thought would be suitable to be included in the research. This resulted in interviews at QUT with three more participants who were employed in full-time jobs within local and state government. Following advertising of research participants on the *Bluelight* drug forum, one participant, a full-time worker, expressed an interest in being interviewed. He was provided with the relevant participant information sheet and was subsequently interviewed at QUT. In total, 29 people aged 18 to 25 years were interviewed for the research, (female=10, male=19). Of these, nine participants, three of whom identified as Indigenous, were recruited from the youth service, 16 were recruited from three separate Brisbane universities, and four were recruited through students' friends and through *Bluelight*.

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[41] Snowball sampling is a method that helps locate 'information rich' interviewees (Patton 2002, p. 237). It is also an ideal way to locate participants with particular characteristics and is especially suitable for research involving difficult to reach populations such as illicit drug users (Berg 2007, p. 44).

[42] Bluelight provides links to information such as 'safe pill reports', and is an advertising space for researchers seeking research participants http://www.bluelight.ru/vb/forums/45-Australian-Drug-Discussion

The different participant groups conformed, with almost no exceptions, to quite specific sociodemographic characteristics. The students and full-time workers all had a university education, and had aspirations of a career, home and family. In contrast, none of the young people from the youth service had a university education, the majority had left school by the age of 15, none were employed at the time of interview, and most reported being homeless or living in temporary accommodation. Consistent with the review of literature, participants in each group reported using particular types of drugs and reported quite different reasons for their drug use. Cannabis was the only substance used by almost all the participants regardless of their sociodemographic characteristics. Analysis of participants' drug use was based on the numbers of young people who reported current or previous use of a drug on a regular basis. Regular drug use was defined in terms of weekly to fortnightly use for a period of at least two months, or intermittently over a longer period. Many of the university students and full-time workers used drugs for short periods of time, then stopped and resumed their drug use again at a later date. While several of the university students reported using legal or 'herbal' highs, all participants reported that their use was a one-off isolated occasion when ecstasy was unavailable; therefore legal highs have not been included in the analysis in Table 2. Young people at the youth centre however, typically reported using drugs on a daily basis. Table 2 provides an analysis of the illicit drugs young people reported using, according to the numbers of young people who reported using each drug:

Table 2. Analysis of groups and their drug use

Group	Ecstasy	Amphetamines	LSD	Cannabis	Heroin	Oxycodone	Xanax	Inhalents	Other prescription[43]
Youth service		8		8	4	9	7	2	8
Students	15	3	4	15					
Full-time workers	3	1	1	4					

[43] Young people from the youth service were using the synthetic opioid Buprenorphine, methadone, sedatives and a range of benzodiazepines, particularly Valium and temazepam. These substances were not used according to medical prescription but were generally acquired through peers undergoing treatment programs.

Interviews

Confession and the construction of a drug user self

Atkinson and Silverman (1997, p. 305) argue that contemporary sociology seeks the authentic narrated experience through research interviewing and, in doing so, promotes a particular view of narratives of personal experience. With its implied self-revelation of the confessional, the interview is a technology for the production of selves, biographies and experiences, which promises privileged glimpses into the private domain of the narrator. In the confession of the research interview the speaker is constructed as a witness of their own unique biography and therefore is both the subject and object of their own authentic account of private experience (Atkinson and Silverman 1997; Keane 2001). According to Foucault (1978, p. 61), the confession is a power relationship between the subject and the authority of the interviewer in which the speaker creates his or herself as a subject through a ritual of discourse. From this perspective, the researcher/interviewee relationship is a confessing ritual in which the truth is formulated by the revelation and endorsement of the experiences of the narrator (Atkinson and Silverman 1997, p. 315). The method employed in the current research does not assume a universal truth or a revelation of the 'true' identity of the drug user. Rather, the focus of the research interviews was to understand how self-revelation of the drug user necessarily reproduces, yet simultaneously undermines, notions of an addict or drug user self, and how this self is located in historical, social and institutional contexts (Keane 2001). The research interviews enable the notion of the self, as an essential identity, to be destabilised in place of the addict or drug user who is not a product of their drug use, but rather is a site of negotiation between governmental and institutional practices, and the self. This interplay of government and the self will be illustrated in Chapter Six.

Conducting interviews

Consistent with an ethnographic approach, interview data was collected using semi-structured, partially open-ended interviews, enabling the researcher to capture participants' feelings, beliefs and practices. Semi-structured interviews were used because they have a set interview format, yet allow enough flexibility for the researcher to probe and clarify responses (May 2002, p. 123). The interviews were

based on a self-designed questionnaire which allows for prompting and expanding in order to obtain more information and clarification if required[44]. Interviews with service providers and other professionals were conducted in Brisbane and Sydney for approximately 60 minutes. Interviews with drug users were conducted face to face in Brisbane and lasted from 40 minutes to 90 minutes.[45] All participants were offered the option to receive a final copy of the thesis and report about whether it reflected their experiences.

Data analysis

Transcription

Data was transcribed verbatim by the researcher immediately after each interview. The method of self-transcription was preferred as it enables a familiarity with the data and assists in the identification of common themes. All interviewees were provided with an option to receive copies of their interview transcripts and were encouraged to review the accuracy of the data and report any inconsistencies to the researcher prior to the analysis. This allows the researcher to be more confident of the accuracy of transcribed data according to accounts provided by participants (Lincoln and Guba 1985; Silver 2001).

Data coding and analysis

Data analysis for the research is consistent with an ethnographic approach, which allows the data to emerge, develop and unfold (Hammersley and Atkinson 2007; Lincoln and Guba 1985). Thematic analysis was used to identify key themes in each data set. Thematic analysis is a form of pattern recognition within the data, where emerging themes become categories for analysis by using coding. This allows the narratives to emerge from interview data rather than from a pre-existing literature review or theoretical framework (Patton 2002). The themes that occur most frequently generate the coding scheme that is used to analyse the data. In exploratory

[44] Interviews were digitally recorded with permission from participants. All recorded information including transcripts of interviews have been stored in password protected computer files and locked filing cabinets.

[45] At the conclusion of the interview all participants were offered a Coles-Myer gift voucher to the value of $20 as a token of thanks for their participation in the research. While none of the service providers accepted the voucher, it was accepted by all of the drug user participants.

studies such as the current research, the coding scheme allows for flexibility and richness and enables the researcher to generate explanations from the findings (Frankfort-Nachmias and Nachmias 1996, pp. 337-338).

Analysis of data from interviews with service providers and other professionals

The first stage of the analysis involved coding themes emerging from interviews with drug service providers and other professionals into four parts, with the aim of capturing how expertise plays a key role in contemporary forms of political power. As summarised in Table 3, these parts were loosely categorised into work role, perceptions of the drug problem, professional objectives/goals, and strategies to achieve objectives.

Table 3. Codes used in thematic analysis of interviews with drug service providers/other professionals

Professional role	**Perceptions of the drug problem**	**Professional goals**	**Achieving objectives**
Professional title, role and client group	Perceptions of the problem of illicit drug use (e.g., a legal/health problem, an illness).	How the service provider/professional's role meets the objectives of their organisation/agency and broader policy objectives.	Strategies, techniques and professional practices to meet organisational and policy objectives.
	Perceptions of how the drug problem can effectively be governed.	Perceived responsibility of client group in meeting organisational/policy objectives.	Effectiveness of current strategies and anything else that could be done.

Analysis of data from interviews with young people

The second stage of the analysis coded themes emerging from interviews with young people into four parts. The codes aimed to capture the ways in which young people respond to the government of drug use, and how they govern their own drug use practices. As summarised in Table 4 below, codes were loosely categorised into the young person's sociodemographic characteristics and the types of drugs they used, the contexts of their drug use, the forms of governance they experience and their perceptions of constraints on their drug use, and conceptions of their selves as drug users.

Table 4. Codes used in thematic analysis of interviews with drug users

Sociodemographic characteristics	Contexts of drug use	Governance	Drug user self
Education, family, living conditions for each group; types of drugs used by young people in each group	Reasons for using drugs (e.g., leisure/pleasure or habitual/addiction).	Everyday formal and informal constraints on drug use (e.g., family, police, health service, corrections, psychologist, friends, university, workplace).	Perceptions of self as a drug user (e.g., an addict, a successful person having fun, a victim).
	When and where drugs are used (e.g., on weekends/holidays at a party/club, everyday at home/with friends).	Responses to constraints (e.g., restricting drug use, changing types of drugs used, more careful, seek help, using more drugs).	Expectations of future drug use (e.g., a passing phase before having a good career/starting a family, no hope of stopping drugs, aspirations to overcome drug problems and help others).

Application to a governmentality framework

Following the coding and identification of key themes emerging from interview data in stages one and two, the final stage of the analysis grouped emergent themes into Foucault's key concepts of governmentality. This stage of the analysis allows for an understanding of how expertise as a form of political power creates governable subjects who self govern their own drug use. Key governmentality concepts used in the analysis are summarised in Table five below:

Table 5. Governmentality concepts applied to interview themes

Drug service providers and other professionals	Illicit drug user groups
Problematisation of government	Knowledge, truth and power
Knowledge, truth and power	Objects and subjects of governance
Normalisation and biopolitical technologies of government	Neo-liberal responsible individual
Neo-liberal objectives of government	Practices of the self

These governmentality themes are consistent with the aims of the research to understand the historical and political contingencies of the contemporary governance of drugs and the 'truths' that are produced and reinforced by scientific knowledge.

The themes allow for an understanding of how governmental rationalities operate according to the objectives of government in neo-liberal societies. They also allow for an investigation of how young people's drug use practices are formed through the interaction of the governance of drugs and their own subjectivity. Chapter Five and Chapter Six will use interview data to explore these topics further and will illustrate how drug use and drug users are governed by forms of external authority and self-governance of the drug user.

Conclusion

The governmentality concepts outlined in this chapter provide a framework for analysing the historical problematisation of drug use and drug users that emerged during the biopolitical age. An account of the problematisation of drugs provides a point of departure for understanding the governance of drugs in the context of everyday practices of neo-liberal government. Chapters Two and Three of this thesis have provided a foundation for an analysis of how drugs have come to be understood as a problem for governments and how they have been managed through a range of techniques that support the rationalities of government. This chapter has provided an overview of how Foucault's concept of governmentality allows the historical foundations of the drug problem to be integrated with interview data in Chapter Five and Chapter Six. These chapters will illustrate how forms of authority in the government of drugs have been problematised and shaped to address what has been made the 'drug problem'. They will also allow for an analysis of how young people self-govern their drug use and form particular drug user subjectivities within these authoritative forms of government.

This chapter has explained the relevance of governmentality to the approach taken in the current research. Consistent with Foucault's commitment to disrupting knowledge, the research seeks to challenge perspectives that take for granted a pre-given 'drug problem', and to analyse drug use as a problem produced within relations of power. The chapter has outlined the approach taken in the research, and described the methods and data analysis for the thesis. Foucault's method is used with an ethnographic approach to explore the government of drugs and drug use, and how governance interacts with young people's drug use practices. Themes identified

in data from semi-structured interviews with 15 service providers and professionals, and 29 young people form the basis of Chapters Five and Six.

CHAPTER FIVE: GOVERNING THE DRUG USER

The previous chapter outlined key concepts of governmentality as a framework for the research, and explained the relevance of Foucault's method to the current thesis. Against the historical background of Chapter Two, this chapter analyses data from interviews with 15 drug service providers and other professionals[46] whose specialisations are in the fields of public health, law and law enforcement, drug education, psychological and counselling support, and research. Within a governmentality framework, this analysis seeks to understand the historical, social and political contingencies that have made drugs a problem in contemporary societies. The chapter addresses the first of the research questions by exploring the technologies that govern drug use and drug users, and how these forms of governance are shaped within relationships between knowledge, truth and political rationalities.

The first part of the chapter explores how drug users are variously represented as a biopolitical problem. This is illustrated through interview data, which highlights how variations of nineteenth century problematisations of the diseased, pathological drug user, manifest in the contemporary representations of the 'problem' drug user. The second part of the chapter analyses the shift from welfarism to neo-liberalism, in which drug users are encouraged to govern their own drug use through harm reduction technologies, rehabilitation and self-reformation in line with the objectives of government. The data illustrates how, in Australia and other neo-liberal societies, the government of drug use does not seek to simply coerce or force compliance, but, rather, manages risk through various responsibilisation strategies to encourage the individual to manage their own drug use. The final part of the chapter presents participants' views on the failure of governmental efforts to control the 'drug problem'. This is discussed in the context of Australian political discourses of illicit drug use that sustain law enforcement efforts in spite of public perceptions that such measures have failed to meet their own objectives.

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[46] Data analysed in this chapter is derived from interviews with police officers Ray and Jim; medical doctors Dr Matthew and Dr Stephen; barrister Jack; drug intervention workers Tom and Lorraine; drug educator and researcher Michael; health education workers Rob, Sue and Louise; events coordinator, chemist and researcher Bill; drug counsellor Ben; and community development worker Rose.

Bio-politics of the Problem Drug User

Creating abnormal individuals

In *The History of Sexuality, Volume 1*, Foucault (1978, pp. 140-146) discusses the emergence of law and medicine in the eighteenth century as a part of the development of the moral regulation of populations marking the beginning of the biopolitical era. Law performed a regulatory function, operating as a norm in apparatuses such as medical and administrative institutions, which gave rise to a range of techniques of regulation for the management of populations. The medicalisation of society during the eighteenth century manifested as a range of health conditions, and was characterised by a growth in medical professionals, family health care, private consultation, and diagnoses and therapy (Foucault 1980c). As an element of biopolitics, the 'drug problem' was created in the process of establishing and legitimising the medical profession, and the development of a medical market (Berridge and Edwards 1987; Foucault 1980c). According to Canguilhem (1991), it was between the mid eighteenth century and the 1830s that the words 'normal' and 'normalised' first appeared. There was, however, a distinction between social norms as technological and institutional, and organic norms, such as those defined in biological characteristics of individuals.

By the nineteenth century, new knowledge, techniques and interventions were being generated through the sciences, the object of which was the health, conservation and protection of the population. The work of the English public health reformer, Edwin Chadwick, discussed in Chapter Two, was central to developments that emerged from these biopolitical concerns of the population. The health of the population became a new object of analysis and medicalisation came to connect practices of police[47] with a new body politic of population (Pasquino 1991, pp. 115-116). At the same time, the systematic collection of statistical data became fundamental to knowledge of the population and impacted on how societies were conceived and individuals described (Hacking 1990, p. 3). Statistical expertise enabled analysis of

[47] Police in this context refers to a totalising exercise of government; a biopolitical project to administer multiple domains of the population (Osborne 1996, p. 100). This exercise of government extended its practices and knowledges to areas of assistance, tutelage, medicalisation, and the prison and its disciplinary mechanisms, sexuality, psychiatry and the family (Pasquino 1991, p. 116).

rates of illness, disease and mortality, and identified sites of disease and epidemics and correlates between cases and population characteristics (Petersen and Lupton 1996). As mentioned in Chapter Two, it is for this reason that insurance companies, which substantially influenced the public health movement of the nineteenth century, were so concerned with the collection of statistics of the health of the population. Statistical knowledge has since been fundamental to shaping modern medical technologies of governance, and the determination of law and the character of social facts, encompassing problems such as drug addiction, crime, prostitution and divorce (Hacking 1991, p. 181). Statistics enabled problems such as disease, deviance and pathology to be calculated on averages, defined and diagnosed as a deviation from the norm, and presented as 'facts' based on categories of 'normal' and 'abnormal' (Hacking 1990). Medicine and its interventions subsequently became concerned with achieving normality, defined according to a standard of functioning (Foucault 1994d, pp. 32-35). What was created was not simply State intervention in the practice of medicine, but, rather, the identification of sites in the social body, health and disease, law, crime and punishment, poverty, madness, and family life, requiring governance through a variety of political roles (Foucault 1980c; Rose and Miller 1992). It was in this medical context, and under the influence of scientific positivism that homosexuality, insanity, drug addiction, poverty and crime, were reclassified as biologically determined and, hence, as inherent characteristics of 'abnormal' individuals (Berridge and Edwards 1987; Hacking 1990; Royal Commission into the non-medical use of drugs, South Australia 1978).

According to Foucault (2003a), during the nineteenth century, medico-legal practice produced a psychologico-moral double of the legal offence, the 'dangerous individual', and the 'abnormal individual'. Foucault (2008b) describes how public anxieties surrounding danger and security for the population were located in fears about disease, sexuality, crime, race and so on:

> ... you see the appearance of detective fiction and journalistic interest in crime ... there are campaigns around disease and hygiene ... and ... sexuality and the fear of degeneration ... of the individual, the family, the race, and the human species ... everywhere you see ... the fear of danger ... (Foucault 2008b, pp. 66-67)

These fears brought particular groups and behaviours under scrutiny, for example, the sexuality of children, the mad, criminals and homosexuals (Foucault 1978, pp. 38-39). With concerns to protect the interests of freedom for populations, the nineteenth century homosexual became a type of person, a medical and psychological anomaly, and a species (Foucault 1978, p. 43). At the same time, the pathologised 'addict' became an essentialised category (Foucault 2008a).

Disease, epidemiology and socially efficient conduct

While medical knowledge was concerned with individual health, the emergence of the collective enterprise of public health during the nineteenth century was able to encompass broad categories of the population and environment, including regulation of psychological, social and physical elements (Petersen and Lupton 1996, p. ix). At the same time, a new medical-juridical authority associated irresponsible 'socially inefficient conduct' such as criminality, immorality, and unproductiveness, with mental health, the solution for which was prevention and mental hygiene through public health (Rose 1985; Sedgwick 1992). Epidemiology, as a field of public health research during the same period, as mentioned in Chapter Two, analysed statistical links between disease, epidemics and the 'inherent' characteristics of individuals and populations, in particular the working classes. Epidemiological research based on methodological assumptions of correlations between individual characteristics and disease, influenced perceptions of various health conditions and the prescriptions that have since been made for their treatment. A contemporary example of this is how epidemiological data of HIV/AIDS has, until recently, constructed the disease as predominantly the domain of gay men and other 'deviant' groups such as injecting drug users and prostitutes (Petersen and Lupton 1996, p. 37).

The historical relationship between disease, epidemiology and the illicit drug user has allowed for an understanding of how the drug user has been variously represented between the nineteenth century and late twentieth century. These representations broadly encompass the pathological individual with a 'disease of the will' (Valverde 1998) from the nineteenth century; the disease carrying subject of subterranean cultures during the 1960s (Howard and Borges 1970; Levine 1974); and the potential HIV/AIDS carrier from the late twentieth century (Robertson et al.

2006). During an interview for the current research, a comment by Bill, an events coordinator, chemist and drug researcher, illustrates how injecting drug use in the twenty-first century is primarily understood as a public health and safety issue. Bill's organisation attends music festivals and various other events to look after young people using party drugs such as ecstasy. However, due to a political concern with drug users as potential carriers of HIV/AIDS, and a harm reduction focus on the prevention of disease, the organisation does not receive government funding:

> … [our organisation] has been going to festivals for 12 years now … we set up a tent, give out free water and look out young people who have OD'd[48], sick or are freaking out … we get no government funding … what we do is harm reduction but it's been easier for the government to accept needle exchanges than being safe within the dance scene because there's all the public sentiment about addressing the AIDS and hep C problem … it's a public safety issue. (Bill, events coordinator, chemist, drug researcher)

Bill's comment illustrates how governmental responses to illicit drug use selectively focus on 'harms' related to injecting drug use, from a range of possible harms that are made up of concerns about the threat of disease associated with particular sections of the population. This is an example of how public health and epidemiology as technologies of government, have become the producers of 'truth' about illicit drug use, making problems of illicit drug use thinkable and governable in new ways.

Variations of the pathologised addict

The problem drug user is a relatively new phenomenon, derived from the pathologised addict. According to Berridge (1990) and Seddon (2011a), the problem drug user can be traced to the eugenic and racial views about mental deficiency and the scientific research of CP Blacker of the Eugenics Education Society in Britain[49], discussed in Chapter Two. According to Berridge (1999) the increasing awareness of drug addiction in the 1920s and 1930s was underpinned by psychological theories which pathologised habitual drug use and laid the foundations for post-war practical

[48] Overdosed.
[49] During the same period, pathology came to be conceptualised as a biochemical error (Canguilhem 1991, pp. 275-277).

developments in treatment, such as the work of Jerome Jaffe referred to in Chapters Two and Three. Mutations of the nineteenth century pathologised addict are illustrated in research interviews where participants variously discussed their views of drug use as problematic. Themes of pathology, mental illness, and a causal link between drug use and addiction, were evident in their comments; reflecting not only their perceptions of drug use, but also contemporary rationalities in treatment policy and practice. Health education workers Rob and Sue are committed to a harm reduction approach and view the problem of drug addiction as a pathological condition and hence, a medical problem. Throughout the research interview Rob and Sue spoke in unison about their role in assisting drug users to maintain their drug use while minimising harm:

> Drug addiction is a chronic relapsing condition ... we see people going away from us for a while then coming back after a period of time … we argue that drug addiction should be seen as a medical health issue, not a legal one. (Rob and Sue, health education workers)

Drug counsellor and educator Ben views addiction as an inevitable consequence of drug use and a condition that interacts poorly with mental illness:

> People start off partying and they look around and they've got an addiction … (Ben, senior duty counsellor and education facilitator)
>
> … pot is a big problem with all the stronger hydro around … those with poor mental health go off their psyche drugs and self-medicate with pot … or whatever … others get prescribed something by a psychiatrist and take it in addition to illicit drugs … the ones who come here must be under a psyche or case manager … (Ben, senior duty counsellor and education facilitator)

General Practitioner Dr Stephen believed addiction is a direct consequence of illicit drug use and abstinence programs are the logical solution:

> I'm seeing far higher levels of pathology, shorter life span … once they get to their 30s they're bound to start getting things wrong. (Dr Stephen)
>
> About 80 percent of my patients are illicit drug users. They have a primary drug they're addicted and usually use a range of other substances in addition—mostly opiates, cannabis and amphetamines. I like it when they get vein damage

> because it means they can't shoot up any more and they come and get help ... I … believe in … abstinence … (Dr Stephen)

In contrast to the views of inevitable harm, drug educator and researcher Michael was critical of the notion of necessarily problematic illegal drug use that automatically leads to addiction. His criticisms are supported by Coomber and Sutton's (2006) study discussed in Chapter Three which found that it can take up to 12 months of regular drug use to become addicted to a substance such as heroin. During an interview, Michael argued that the notion of a causal link between illicit drug use and drug addiction is a myth, as it takes a very long time to become addicted to drugs, and addiction is not an inevitable consequence of addictive drugs:

> We've got this classic myth that one try and you're addicted … When the heroin shortage came there was this huge concern that we were going to see all these people going through terrible withdrawals and dying … and it simply didn't happen. (Michael, drug educator and researcher)

> … without any doubt, if you have a good time the first time you use heroin … and many don't ... many people will just be violently sick ... but if people have that euphoric feeling … what do they say in 'Train Spotting' … take the best sex you've had and multiply it by a hundred? … now you're certainly not going to get physically addicted to it because that takes ages … like regular use... but psychologically dependent ... because it's like "oh my god, that's so great, I'd like to feel great again". (Michael, drug educator and researcher)

With the exception of Michael's comments, participants' views reflect the medico-legal and medico-moral constructions of illicit drug use as necessarily problematic since the nineteenth century. These conceptions of drug use, particularly illicit drug use, have resulted not simply from knowledge of chemical harms, but also the production of medical, legal and political discourses relating to dangerous individuals, individual pathology and social harms (Brown et al. 2001; Royal Commission into the non-medical use of drugs, South Australia 1978). In this context Seddon (2011a, p. 334) argues that remnants of the eugenics program have persisted in the drug field today through various problematisations and conceptualisations, which have shaped the ways in which the 'problem drug user' is governed. Rose (1999a) argues that in producing scientific knowledge, it has been

possible to govern individuals, not on simple authority, but as scientific subjects. The 'psy' sciences, their scientific affiliates and their forms of expertise, have played a key role in creating 'governable subjects' whose conduct may be deemed detrimental to population health, and therefore, render them subjects of scientific expertise.

The problem of dysfunction

Problem drug users are not necessarily defined as such solely on the basis of their use of a particular chemical substance. Rather, 'problem' drug use is generally perceived as practices that result in reduced social functioning[50], a weak relationship with the social environment, and a risk of the user engaging in crime (Levine 1978; Seddon 2011a; Valentine 2007; Valverde 1998). According to Seddon (2011a), the contemporary problem drug user, defined by a lack of social functioning, is derived from the notion of the rational, functional individual. The contemporary notion of the rational, functioning drug user is a variation of the Earl of Mar who was depicted by his insurance company as a 'rational' opiate user. Other examples are evident in the liberal individual of the late nineteenth century who had a 'disease of the will', and the functional citizen of colonial Australia who refrained from inebriety.

According to Seddon (2011a), however, the category of the problem drug user has not replaced notions of the addict, but has expanded and multiplied the possibilities for concepts of the drug user. Seddon (2011a, pp. 340-341) argues that we now have a complex suite of related yet overlapping concepts that are deployed in different ways and in different contexts. While some of the moralistic dialogue around 'drug abuse' has reduced, the more pragmatic, problem-oriented perspective of the 'problem drug user' opens up possibilities for numerous descriptions of activities that uncritically make causal links between individuals and 'drug-related' problems. For example, during interviews drug service providers and other professionals variously described their perceptions of the problem drug user in terms of the individual's social functioning. Themes that emerged from interviews were mostly related to the

[50] Similarly, Derrida (1993, pp. 7-8) argued that a concern regarding standards of functioning of the drug addict, such as self discipline and exile from the social world, does not extend to the alcoholic or smoker. He argued that it is not the drug addict's pleasure per se that is considered problematic, but rather the addict's lack of productivity and participation in consumption. According to Derrida (1993) it is non-work, and a lack of responsible effort that is the problem, and it is in the name of authentic work and responsible effort, that drug addiction is condemned.

drug user's relationships, financial security, employment, mental health, criminality and domestic functioning. For Rob and Sue, Lorraine and Michael, drugs become a problem when they start to control the user by impacting on their social functioning:

> The way we look at drug use is its effects on your functionality of life … it's when the drug use outweighs the functionality that it's a problem … functionality is sociability, financial security, relationships, etc. (Rob and Sue, health education workers)

> When the drug starts to control them and becomes a dependency it's a problem. (Lorraine, drug intervention worker)

> I've seen people have huge problems with ecstasy … where they couldn't mix socially … could not go out to a party without using it … because it takes a while to recover from that drug … it meant that they couldn't go to work on Monday, they had relationship problems, so life crumbled … (Michael, drug educator and researcher)

These comments illustrate that some drug users experience a range of difficulties and adverse effects as a consequence of their drug use. What is salient in these discourses however, is that they represent the ways in which problem drug users have come to be correlated with factors such as unemployment, poor social relationships and lack of financial security. According to Seddon (2011a), these characteristics construct a distinctive class or category of person, or according to the terminology of the Eugenics Society a 'social problem group'.

Neo-liberal Rationalities of Government

Governing at a distance

Since the 1970s, welfarist concerns with social problems such as delinquency and anti-social behaviour, the problem family, and health and illness, have been replaced with individual and collective entrepreneurialism in social services (Rose and Miller 1992). Social benefits that were previously provided as welfare services are now accessed through purchase in a privatised, competitive market (Rose 1996a, p. 343). According to Castel (1991) this rationalisation of services is characterised by new technologies that do not need to operate through repression or through welfare

interventionism. Rather, they develop modes of treatment which aim to maximise returns through profitable practices while marginalising the unprofitable. For example, rather than forcibly applying corrective or therapeutic interventions, newer technologies have enabled the maximisation of profit through regulation and intervention (Castel 1991, p. 294). Rose (1993) argues that this has been made possible using technologies of social regulation and reformation that operate to enable individuals to manage themselves (Kelly 2013). These technologies encourage self-management through various practices of self-evaluation and reflection to achieve an individual regulated freedom in which citizens govern their lives and conduct (Rose 1993, pp. 227-228, 291).

Freedom is made possible through self-management which is facilitated through the guidance of experts whose objectives are aligned with those of political authorities, such as doctors, social workers, managers and educators (Rose and Miller 1992, p. 180). This form of governance is referred to by Rose and Miller (1992) as 'governing at a distance' as it allows individuals to be governed indirectly and away from the centre of authority, rather than by direct interaction between the governor and the governed[51]. From this perspective, individuals, as free liberal citizens, are not directly governed, but govern their own conduct and practices, as the following chapter reveals in respect to drug use. Rose (1999b, p. 193) uses the term 'ethico-politics' to describe the management of one's own conduct. In the context of governing drug use and drug users, ethico-politics is a form of technical management which describes the ways in which professionals and drug service providers conduct themselves in order to produce politically desired ends. Ethico-politics enables autonomy and diversity while simultaneously facilitating the need for authoritative judgments of good and bad, and right and wrong (Rose 1999b, p. 170). In this regard a fixed code of conduct is transferred from the moral authority to the individual, to allow the individual to take responsibility for their own self-management, in order to achieve better governance (Rose and Miller 1992; Rose 1999b). From this perspective, governing is not a form of coercive control or the antithesis of freedom, but rather control through the governing of freedom (Foucault 2008b, p. 68).

[51] This style of government is characterised by regulated autonomy and responsibilisation; however Rose and Miller (1992) argue that rather than autonomising the family, this mode of government increases the possibilities for governing it.

Crime, risk and drug use

From penal welfarism to risk management

The welfarist criminal justice system was characterised by discretionary sentencing practices, and notions of pathology, based on individual characteristics and family background (Garland 1985). Under penal-welfarism, incarceration for young people was justified on the basis of social work interventions and the need for 'care and protection' (Carrington 1993). This resulted in criticisms from civil libertarians and liberal lawyers that the justice system placed excessive restrictions on individual liberty and undermined the offender's right to natural justice (Muncie 2005; Carrington 1993). By the late 1970s, discretionary practices of penal-welfarism were replaced with a 'just deserts' law and order approach (Hogg and Brown 1998; McCallum and Laurence 2007). In some contemporary judicial systems, for example, some Australian and some other Western jurisdictions, law and order approaches now include mandatory 'three strikes' sentencing. This legislation has been found to impact disproportionately on those whose crimes are most likely to be covered by mandatory incarceration, particularly young people, Aboriginal populations and socially disadvantaged groups (Carrington 1993; Hogg 2007; Muncie 2005). In the current research, Jack, who spent 15 years as a barrister defending young Aboriginal people, explained that legislation banning alcohol in Aboriginal communities has provided police with extra powers to search and arrest. The legislation, coupled with mandatory sentencing laws, have impacted negatively on Aboriginal people, as Jack explains:

> Under the Liquor Act the police can search a back pack … the person is charged with possession and trafficking. Under the mandatory Northern Territory sentencing laws the person can receive a very long sentence … the argument is that the effect of drugs on the Indigenous community is so rife that the penalties can be up to 10 years … so the first time trafficking offender pretty much goes to gaol. It doesn't matter how small an amount it is, even for a joint an Indigenous person can end up in gaol … what's the common good in that? ... taking someone away from their community … using tax payer money to incarcerate them … then flying them back to their community after gaol just to put them back in the same situation. (Jack, Aboriginal barrister)

Punitive law and order programs, such as mandatory sentencing laws, are part of the neo-liberal justice system, which, according to Muncie (2005), is characterised by a co-existence of harsh punishment with a complex of rehabilitative and responsibilising strategies, aimed at self-regulation of the offender. This arrangement of punishment and self-reformation transfers responsibility to the individual for their own self-regulation. Those who refuse to comply, or cannot comply, may be susceptible to rehabilitative and reformative therapy within a prison or rehabilitation facility. Similarly, Garland (1997, p. 185) argues that the shifts in the criminal justice system in recent decades have resulted partly through a need to address high crime rates and the failure of criminal justice controls; however, they are also a consequence of shifts from welfarist forms of government to neo-liberal ones. According to Garland (1997), risk-based neo-liberal government encompasses an 'economic rationalist' style of crime control characterised by an increasing reliance upon language of risks, rationality, choice, probability and targeting. There is also a key focus on the importance of objectives such as compensation, cost-control, harm-reduction, economy, efficiency and effectiveness, and technologies such as audit, fiscal control, market competition, and management and control of penal decision-making (Garland 1997, p. 185). Agencies that police the behaviour of populations deemed problematic exercise a political power that does not seek simply to make individuals subjects of power. Rather, the objective is to create autonomous individuals with the capacity to self-regulate their conduct and their relations to others. The focus of these self-regulatory techniques is reform, consistent with enhancing economic efficiency in non-economic domains, such as health, education, labour markets and so on (Hogg and Carrington 2001, p. 57).

Managing risky populations

In *Madness and civilization*, Foucault (1988b, 245-246) argued that the asylum was a site for restoring the 'madman' to self-discipline by instilling reason and moral responsibility to ensure that 'he' [sic] does not disrupt social order[52]. The notion of moral responsibility as a form of self-discipline replaced forced restraint and control through chains of the 'mad' prior to the development of the asylum. This shift

[52] In Australia 'dangerous lunatics' were housed in asylums under the *Dangerous Lunatics Act* (1843) (McCallum 2008, p. 70).

occurred during the nineteenth century under the economic and political power of the middle classes, whose notions of social order through self-control and self-discipline rendered the madman morally responsible for regaining control. Madness, then, became curable and the individual responsible for their own cure. Against this social backdrop, the Temperance Movement, which endorsed the notion of maintaining personal control and self-restraint, easily found support among the middle classes to help addicted individuals who struggled with their 'inner desires' (Levine 1978, p. 165). Levine (1978, p. 163) argues that, in the past 200 years, expectations of the drug user to control their behaviour have been shaped by developments in nineteenth century thought about mental illness and deviance more generally.

During the nineteenth century, middle class problematisations of young people of the poorer classes as delinquent and disorderly, turned the institutional gaze to those perceived as dangerous; the unemployed, scavengers, prostitutes and petty criminals (Carrington 1993). In Australia, a growth in preventative and curative welfare and scientific technologies for governing the behaviour of young people resulted in a blurring of child neglect and delinquency and a widening of the net of offences deemed punishable through incarceration (Carrington 1993; McCallum 2004). At the same time, statistics became a technology for identifying problem populations and enabling distinctions between normality and pathology to become crystallised into legislation and integrated into the activities of extra-judicial experts, and in the disciplinary techniques deployed in policing risk and dangerousness (McCallum 2004; Carrington 1993).

In Australia, 'high risk' populations are especially susceptible to policing, particularly those committing minor violations, such as drinking in public or being under the influence of illicit drugs (Carrington 1993; Muncie 2005). In the current research, observations made by community development worker, Rose, and drug intervention worker, Lorraine, illustrate how law enforcement as a strategy of intervention operates to manage drug users or young people perceived as dangerous or 'risky':

> I can't tell you the number of times I've looked out this window and seen cops grabbing people as they leave the NSP. (Rose, community development worker)

> … the Valley police frequently pull up certain young people, some of them five to 10 times a day just from walking down the street. They may not actually be doing anything, but they'll get pulled up and then name checked … the police know their families too … (Lorraine, drug intervention worker)

The comments made by Rose and Lorraine illustrate how drug users are policed according to neo-liberal, risk-based, rationalities of government. Those suspected of being problem drug users, such as individuals leaving the NSP, have been identified as a particular type of problematic drug user (Seddon 2006; 2011a). As noted in the literature review, people who regularly use heroin or other drugs of 'dependency' are likely to be defined as socio-economically deprived and involved in drug dealing or other crimes. Their defining features, as such, are the use of heroin and its uncritical link with unemployment, poverty, homelessness and other social disadvantages (Seddon 2006; Pearson 1996; Zinberg 1984). Such problems do not exist in themselves, rather, they are created through knowledgeable discourses that represent and constitute objects of knowledge, such as unemployment or illicit drug use, and confer particular identities, such as the dangerous individual or the criminal (Dean and Hindess 1998, p. 9). The reality of a complex link between crime and the regular use of heroin and some other drugs is unquestionable. What is salient in this link is that historically contingent representations of particular types of drug users have come to manifest as objective and unquestionable truths (Seddon 2006), which inform punitive responses and, in turn, reinforce social exclusion.

Aboriginality and risk

Neo-liberal strategies for intervention and rehabilitation, which coexist with punitive agendas, target inadequate parenting, low self-esteem, poor social skills and limited cognitive skills (Muncie 2005). This is illustrated in comments by Jack, explaining how the judicial governance of young Indigenous people and their families interacts with technologies of normalisation in and out of the court room. He points out that strategies for intervention in the government of the Indigenous child are based on non-Indigenous measures of normality:

> Sentencing decisions made by magistrates are based on normative non-Indigenous measures of risk such as education, housing, family background ... when such standards are applied to Indigenous young people they come up

> looking like a high risk and there won't be too much leniency shown to them … or you might get some social worker coming into the community once a month getting the kid to do some colouring in. (Jack, barrister)

According to Jack's comment, young Indigenous people can be conceptualised according to perceptions of 'high risk' groups whose behaviour is policed through agencies such as the police, welfare, health, school, family and so on; who redeploy moralising techniques of ethical reconstruction in an attempt to facilitate self-management (Rose 1999b, pp. 271-272). Jack also highlighted a tendency within the criminal justice system to detain young Aboriginal people who are perceived as dangerous or risky:

> There's a real tendency to lock Indigenous kids up … When you've got an Indigenous … kid before the courts you've got public enemy number one who constantly steals cars, breaks into houses … there's only one thing that's going to happen—detention. (Jack, barrister)

Jack's comment illustrates how young Aboriginal people are perceived by the police and members of the judiciary as risky and dangerous[53]. Altman and Hinkson (2010) argue that the lifestyles of Aboriginal people living in remote Australian communities are represented as posing an unacceptable risk to neo-liberal societies because they do not behave like other Australians and are not motivated by the same aspirations. The focus of neo-liberalism however, has little relevance for many Aboriginal people. Rose (2000, p. 337) argues that neo-liberalism emphasises the creation of "active individuals who … take responsibility for their own fates through

[53] The focus by the police and judiciary on young Indigenous people can be understood in the context of the formation of racist ideas relating to biological degeneracy during the nineteenth century. Foucault (1980b, p. 233) argues that racism was initially a scientific ideology which manifested everywhere. In *Society must be defended* Foucault (2003b) discusses the development of racism in the late eighteenth century during the rise of disciplinary knowledges and regulatory mechanisms for managing the population. He argues that race becomes a means of defending society from external attacks and regulating itself. Racism was born during the first half of the nineteenth century when a race struggle was replacing a class struggle. Racism reconverted the form and function of the discourse on race struggle so that a historical war was replaced by a postevolutionist theme of the struggle for existence. Hence, it was a biological war; the differentiation of species, natural selection, and the survival of the fittest species. At the same time the theme of the binary society characterised by two races was to be replaced by a biologically monist society. The State as the protector of integrity, with its superiority, purity of race, and monist, Statist and biological implications replaced the race struggle. The notion of deviants as society's by-products was a consequence of concerns of foreigners infiltrating the society. Foucault (2003b, p. 81) argues that it is at the point where racial purity replaced race struggle that racism was born.

… choice … and the management and minimization of risks to lifestyles of contentment and consumption". This neo-liberal ideal is incompatible with reality for most Aboriginal Australians, whose cultures and social and economic conditions are inconsistent with its notions of collective responsibility. Within the neo-liberal individualist responsibilisation framework, the extreme poverty, poor health and high levels of criminality of Aboriginal communities can only be interpreted as fault, deficit and pathology, and subsequently reinforce exclusion (Hogg and Carrington 2006, 2003; Cowlishaw 2004).

Extra judicial apparatuses

Disciplinary networks

Foucault (1977a) argued that there are two processes that ensure the functioning of the prison: Firstly, the reduction of physical possibilities for individuals to commit crimes and, secondly, the growth of disciplinary networks involving the transference of powers, such as medicine, psychology, education and social work, to judicial functions. These extra judicial apparatuses are integrated into functions of the criminal justice system such as drug treatment and rehabilitation programs and diversionary programs, which were discussed in Chapter Three. The objectives of these programs are reform, rehabilitation and realignment of drug users through medical, psychological and educational programs delivered in conjunction with punishment (Foucault 1977a, p. 306). For Foucault (2003a), the integration of legal functions with medicine, psychology and public health education programs, represents a shift from the legally responsible individual to a judgment of the individual's character, their potential for criminality, and their capacity for rehabilitation through techniques of normalisation. Foucault (2003a) explains these techniques of normalisation and the powers linked to them as:

> … a certain type of power—distinct from both medical and judicial power … a type of power that … ends up in the courtroom, by finding support … in judicial and medical institutions, but … has its own rules and autonomy. (Foucault 2003a, p. 26)

Normalising power then, is not simply a combination of medical and judicial power, nor has it become established as a power within a single institution, but has formed

by establishing interactions between different institutions (Foucault 2003a, p. 26). This approach, as discussed in Chapter Three, is favoured in contemporary criminal justice responses to young people's illicit drug use. A comment by police officer Jim illustrates how the integration of health services with law enforcement functions are rationalised in terms of harm reduction:

> Drug law enforcement is about preventing the supply of drugs … but policing is about more than enforcing the law … like networking between service providers, police, health workers … harm reduction policies and aims might not be compatible with police work but that's a tension that can be resolved. (Jim, police officer)

For Foucault (1977a, p. 23) this type of networking is part of a "scientifico-legal complex from which the power to punish derives its bases, justifications and rules …". This complex enables the governance of the social body through non-legal knowledge, techniques and scientific discourses that become entangled with the practices of punishment (Foucault 1977a). According to Rose and Valverde (1998, p. 543) this welding together non-legal forms of knowledge and expertise with normalising, disciplinary technologies constitutes bio-political objectives to reshape the conduct of individuals and population in line with the achievement of governmental ends.

Drug urinalysis

Drug treatment technologies which are tied to incarceration, such as compulsory rehabilitation, and an expansion of penal sanctions, such as tightly sanctioned probation and parole conditions, have to some extent replaced punishment (Rose 1999b, 2000). At the same time, tighter levels of scrutiny and surveillance for participants of drug treatment and rehabilitation programs have been justified on the basis of harm reduction principles. For example, in order to stem the flow of illicit drugs in prisons, prisoners are frequently required to undergo urinalysis and internal body searches. These detection techniques are justified on the basis of minimising the "harm caused by drugs to staff, offenders and society in general" (Queensland

Corrective Services 2006, p. 12). According to Dr Matthew, however, drug detection strategies in prisons such as urine tests[54] are punitive and invasive:

> Corrective Services have a stated harm minimisation policy about drugs, but in fact their model is detection and punishment … like urine tests and putting people back in gaol for positive urine tests … prisoners are subjected to compulsory internal body searches which is rape by law … this is counter-productive. (Dr Matthew)

According to Vrecko (2010a), drug urine testing is part of the relatively new techniques in government control strategies and therapeutic programs. As such, it is an instrument of political power that functions within the prison and in other sites of drug control as part of broader historically constructed techniques and truths for governing human conduct (Dean 1999; Bull 2010).

As mentioned in Chapter Three, drug urine testing is not restricted to prisons, but is also a key element of drug rehabilitation and treatment programs outside of the prison, and diversion programs such as the drug courts. During research interviews, several respondents commented on the high levels of compliance, including urine testing for young people attending rehabilitation programs, or as part of the requirements of the drug court, or as part of their probation conditions. Jack explained that high levels of surveillance and compliance of the drug court involving urine testing, can set Indigenous young people up for failure:

> Reports written about offenders for the drug court by diversion and rehabilitation services … are quite biased … programs are tailored to these reports … those who don't comply with the drug court go to gaol … the offender is usually sent to programs, undergoes regular urine analysis … many

[54] Practices of internal body searches in prisons may be conceived as a biopolitical suspension of rights of personal liberty, where what would normally be considered as the exception becomes the rule, justified on the basis of threat or danger. From this perspective the deployment of exceptional state powers can erode democracy and make exceptional authority the norm (Agamben 1998, p. 2005). Kendall, Woodward and Skrbis (2009, p. 87) argue that it is only through the development of technical innovations that the 'state of exception' can come about. Exceptional powers come into normal existence when there is a political will to strict surveillance, and if opposition to the loss of civil liberties can be effectively stifled through justifications such as the 'war against terror'. In the case of the prison it can be argued that exceptional powers can operate when there is a political will to strict surveillance due to justifications such as policies of zero tolerance of illicit drugs in prisons (Scraton and McCulloch 2009).

> can't comply … there can be issues attending programs for those [Indigenous young people] living in remote areas … (Jack, barrister)

Drug intervention worker, Tom, described the probation conditions for one of his clients, which included strict requirements for drug urine testing:

> I've got one client who did five years in gaol. Now he's out on probation for another two and a half years. He's got three visits a week and gets urine tested. He isn't allowed to have a dirty urine or he goes back to gaol for another two and half years … (Tom, drug intervention worker)

Tom discussed a client's preference for a fine, rather than the high levels of compliance of the drug court:

> One of our clients preferred a fine to the … drug court, there were too many hoops to jump through. He just thought "ah good, done, much better this way, at least I don't have to go to court every second week" … and undergo urine testing. The theme in those programs is 'comply'. (Tom, drug intervention worker)

The technology of urine testing is part of a politics of conduct that problematises the ways in which populations such as criminals, drug users, young people and other excluded groups understand and conduct themselves and their existence (Rose 2000, p. 334). Urine testing and other technologies of control are underpinned by political rationalities to normalise and ethically reconstruct the excluded drug user through remoralising, responsibilising prison drug programs, drug treatments and drug diversion programs (Rose 1999b).

Harm reduction and the management of risk

Self care and responsibility in health care

In Australia, the rationalisation of health care during the 1970s was a response to welfarist health care expenditure which threatened to render health systems financially ungovernable (Lupton 1995; Petersen and Lupton 1996). The rationalist model of health care encourages the transformation of passive patients into active consumers responsible for their own health care through engagement in preventative strategies and treatment programs (Petersen and Lupton 1996). Lupton (1995) argues

that health promotion strategies are techniques of liberal government, directed at populations that constitute biopolitical 'problems' in need of governance by health promotion experts. This model of health care encourages consumers to self-govern their health by engaging in responsible, self-enhancing programs of 'self-help' and 'empowerment' (Petersen and Lupton 1996, pp. 11-12). The broader public health objective is the health of citizens, defined by a regulated body and self-control (Petersen and Lupton 1993, p. 67). While prevention and risk management in health care are the responsibility of the individual, the role of the State and private agencies is to provide individuals with the knowledge and skills to manage their own physical and psychological wellbeing through self-care programs (O'Malley 1996). These strategies of self-governance are underpinned by an ethic of choice which is central to the rationale of policy and also to the reformatory technology employed in neo-liberal societies to implement policy objectives (Rose 2000; O'Malley 1999).

With regard to health programs for drug users, Seddon (2011b, p. 165) argues that the goal of neo-liberal strategies of government is not to change the subjectivity of the drug user, but rather to achieve a particular governmental end through individuals taking control for their own care; failure to do so is deemed a personal failure. A professional reconstruction from the drug addict to the 'health client' is formulated in terms of empowerment, self-esteem and self-worth (Cruikshank 1996). This empowerment approach, according to Rose (2000), is a shift from the patronising logic of dependency that characterised welfarism; however, it redefines the individual's exclusion as a lack of self-esteem, and makes individuals responsible for their social and economic exclusion by forging the solution as a free choice. From this perspective, self-esteem is a practical and productive technology involving a voluntary relationship between the self and tutelary power such as a therapist, social worker or social program, which deploys a specialised knowledge of how to achieve an esteemed self. Self-esteem is not simply for personal fulfilment, but, rather, a social obligation and responsibility, and a social goal that makes people governable. It is, therefore, an economically efficient technology of citizenship whereby individuals evaluate and act on themselves so that police, health workers and other experts are not required to (Cruikshank 1996, pp. 232-234). In the current research, discourse of personal fulfilment and empowerment is illustrated in a comment by

Ben, who described a psychosocial program to educate drug users and provide skills to assist recovery:

> We've identified the impact of drug use on mental health and on families. Our dual diagnosis program deals with this. 'Mud maps' is psychosocial and educational ... educating people about themselves and letting them know what's happening with them … giving them skills while they're in recovery ... nobody is immune to poor mental health or illicit drug use and abuse. (Ben, senior duty counsellor and education facilitator)

Likewise, Lorraine considers that drug use is used as a way of dealing with personal problems and she works to help people discover the triggers to their drug use:

> I don't believe that drug use is ever the only problem. I think people use drugs to cope and drugs are to fill a gap. That's a big part of working with people who use drugs—finding out that trigger—what is the reason behind that use. (Lorraine, drug intervention worker)

Ben and Lorraine have illustrated how drug users are encouraged to work on themselves through empowering self-discovery programs and, hence, to provide them with skills of self-direction, self-management and responsibility to make them 'free' (Rose 2000, p. 334). From this perspective, neo-liberal discourses of freedom, rationality and opportunities to participate in the moral community, situate the individual as ultimately responsible for their social inclusion through their active alignment with moral citizenship (Rose 2000). In the following chapter, young people comment on how they engage in moral responsibility and social inclusion in the self-management of their drug use.

Risk management technologies

During the twentieth century, particularly since the discovery of HIV/AIDS, the government of drug use has focused primarily on managing risk by directing drug users from danger to rational risk-management technologies (Walmsley 2012). According to Castel (1991) and Ewald (1991) risk is a particular way in which problems are viewed, imagined and dealt with; an abstract concept that is calculated through statistical probabilities which enable predictions of harm. From this perspective, risky populations are not governed directly through expertise but

through administrative functions that identify populations or geographical zones deemed to be at risk. According to Castel (1991) this facilitates a new mode of surveillance that is not directed at the dangerous individual but rather, seeks to determine risk through a range of predictive factors such as predispositions, vulnerabilities or susceptibilities (Rose 2001a; Castel 1991). The objective is to protect citizens and reduce harm from populations perceived as problematic (Donzelot 1991). As mentioned in Chapter Three, a moral imperative to manage 'risky populations' from the 1980s, resulted in the medicalisation of 'high risk groups' such as gay men, injecting drug users and prostitutes, and set in motion a range of risk minimisation strategies (Scott 2003,. 2011-2012, 2005; Kinsman 1996; Petersen and Lupton 1996).

Safety and ethical responsibility emerged as key themes in interview data with drug service providers and health professionals, with regard to regulatory strategies in the governance of drug users who are considered to present a high risk of spreading HIV/AIDS and hepatitis C. For example, Rob and Sue commented on the need to reduce the risk of harm in accordance with responsible drug use practices including hygiene, regulation and management. They also suggested that the use of pharmaceutical pills by clients is preferable to heroin, because the pills deliver some assurance of the quality and quantity of the drug:

> … no drug can ever be injected safely but with our service people can spend time preparing their drugs for use ... it's a risky process if they're doing it in an alleyway … we supply and promote the use of clean injecting equipment including wheel filters for injecting tablets … to reduce damage to their veins and reduce unwanted particles going into their blood stream. (Rob and Sue, health education workers)

> It's about quality … the pills deliver a precise quality and quantity every time; with the heroin you never know what you're getting … it's considered to be safer bang for buck because people know what they're getting … the use of Oxycontin[55] is a more manageable process … it comes back to that regulated amount … you know what you're getting … (Rob and Sue, health education workers)

[55] The trade name for oxycodone.

According to Lorraine, educating clients about safe, responsible injecting practices is an important part of providing services to drug users and empowering drug users to safely manage their own drug use:

> We do educational stuff, talking to people about their vein care and safer ways of using, we drum it down their throats. (Lorraine, drug intervention worker)

The quantifiable regularity and assurance of quality preferred by Rob and Sue to manage injecting drug users is a form of risk management. Lorraine's comment about educating young people to exercise self-care in their drug use highlights her role in producing responsible drug users. The notion of responsibility is defined according to individuals who are willing to be governed through hygienist interventions such as harm reduction strategies, in addition to self-regulatory practices such as choosing to use clean injecting equipment (Kinsman 1996, p. 395). The ways in which young people practise these ethical responsibilities will be discussed in the following chapter.

Biomedicine as risk management

In his studies of psychopharmacological technologies of treatment, Rose (2001a) explores the construction of addiction as a disease of the brain. He focuses on the use of the drug naltrexone to treat a range of addictive behaviours, such as alcohol or opiate 'dependency' or gambling, by removing the desire for the substance or addictive behaviour. According to Rose (2001a), the inhibition of desire through pharmacology equates to a flattening out of the psyche of thought and learning, and the re-learning of less damaging behaviour through the acquisition of life management skills. Rose (2001a) argues that while medical knowledge has been at the heart of norms of individuals and populations, we are now seeing normalisation through the government of a neurochemical self aimed at specific 'high risk' groups. In the current research, Dr Stephen, who frequently prescribed naltrexone to his patients, commented that:

> Naltrexone is very interesting ... you can use it for virtually every addiction … opiates, alcohol, gambling, self mutilation, amphetamines, cannabis, cocaine ... it's strong anti-craving. (Dr Stephen)

Other treatments for addiction, such as the Methadone Maintenance Treatment (MMT), are not psychopharmacological and do not act to 'flatten out the psyche' in the way naltrexone does. Rather, MMT is a pharmacotherapy program that acts as an opioid substitution to facilitate the normal social functioning of clients. During a research interview Ben explained the advantages of methadone:

> … methadone … stops them stealing DVD players … and helps them live a normal life. (Ben, senior duty counsellor and education facilitator)

Fraser and Valentine (2008) argue that while methadone clients, as addicts, occupy an invidious position in relation to the normative liberal subject they are also construed as normal subjects of government. The ultimate goal of MMT is not simply to normalise the drug user, but to empower methadone clients to improve their lives (Pedersen 2002, p. 66) by enabling their re-engagement with social institutions such as education, employment and so on (Rose 2001a). Biomedical technologies of drug therapies such as MMT represent a shift from notions of the damaged, defective addict to strategies of normalisation. These strategies aim to resituate the drug user in a realm of the active citizen with a moral obligation to the constant work of adjustment and improvement in response to the requirements of the practices of everyday life (Rose 2001a, pp. 33-34). Rose (2001a) argues that biomedical technologies of drug therapies are part of broader medical interventions to know the neurochemical brain and manipulate its functioning. According to Rose (2001a, p. 36), this is not simply a shift in the boundaries between pathology and normality, but rather a readjustment of our conceptions of our selves. Hence, biomedicine to restore the normal functioning of drug users and encourage self-improvement, becomes a technology of neo-liberal risk management that reduces the potential threat of risky behaviours such as unhygienic injecting practices or crime, which are associated with drug using populations.

Governing drug use through the family

Making up the normal parent

In *Governing the Soul*, Nikolas Rose (1999a, p. 121) suggests that childhood has become 'the most intensively governed sector of personal existence'. Throughout the eighteenth and nineteenth centuries, the family was fundamental to biopolitical

objectives of governing the population, in order to promote marriage, and increase health, wealth, longevity and so on (Rose, 1999a, p. 100). Shaped by these objectives, the modern child has become the subject of a range of technologies to safeguard it from physical, sexual or moral danger in order to manage its 'normal' development and promote attributes such as intelligence, educability and emotional stability[56] (Rose 1999a, p. 124). According to Rose (1999a), since the early part of the twentieth century judgments of normality have become increasingly entangled with psychological assessments and evaluations, and the normal family has become defined in psychological terms as one that produces the normal, adapted child. It is through the development of psychological theories and the identification of dangerous or 'at risk' children that the parameters of the adapted child, and the notion of the adjusted child as the natural outcome of a normal family, have emerged (Carrington 1993; Rose 1999a; Dauda 2010). According to these specifications, the 'normal' family is one which prevents maladjustment such as illegality, inebriety and promiscuity by instilling morality into children (Rose 1999a; Donzelot 1979). The implication of this is that parents who use drugs or whose children use drugs are likely to be deemed to be irresponsible parents and not part of the good government of family life. In the current research, drug counsellor Ben's descriptions of drug using parents provide a contrast to notions of the 'normal family':

> I know a couple who use speed … there's domestic violence, don't keep the house tidy, don't feed the kids properly … this sort of thing goes hand in hand with drug addiction, lack of housing, unemployment, self-harm, incarceration, institutionalisation in a psyche hospital … (Ben, senior duty counsellor and education facilitator)

Ben's comment illustrates how drug using parents have come under the gaze of experts and are subjected to scrutiny in ways that other parents have not. According to Rose (1999a, p. 131), the family is governed yet simultaneously retains autonomy and this facilitates a harmonious relationship between the family mechanism and the goals of government. From this perspective the family is socialised in order that they govern, socialise and correct maladjustment in their child so that the child can

[56] It is in this context that Foucault (1991) argues the family has become the instrument of government rather than the model of good government. From this perspective the family is not coerced or directly governed but governs itself in line with governmental objectives.

become equipped with the skills and knowledge for re-adjustment. The governmental and parental objective therefore is the same; to enable the child to engage with everyday life in the domains of education, employment, consumption, leisure and so on (Rose 1999a, p. 132).

Producing the normal child

Contemporary governance of drug use through the family retains many of the features of the nineteenth century biopolitical objectives of governing through the family to achieve a normal, healthy population. McCallum (1993, p. 134) suggests that the family has become a product of policies designed to reform domestic life, including the behaviour of parents and children. Judgments of the family to assess the risk posed to children generally focus on family and parental background factors to determine the need for intervention (Donzelot 1979; Carrington 1993). According to standards of normality child maladjustment results from conflict, parental expressions of negativity such as disappointments and lack of parental love (Rose 1999a, pp. 159-161). These representations of normal families can be juxtaposed against constructions of the 'dysfunctional' 'problem' parent who does not engage actively with their children and is an inadequate role model (Carrington 1993). According to Carrington (1993) families who fail in their civic duty to properly care for and govern their children may be assessed as dysfunctional and in need of supervision or have their children removed by the state. Historically, the main purpose of this type of supervision has been biopolitical—to manage the effects of family pathology. In her research on the policing of 'dysfunctional' families and delinquent young people, Carrington (1993) illustrates how parental obligations and child safety legislation facilitates the imposition of powers and duties upon authorities such as social workers, psychologists, health workers and teachers. These extra-judicial experts are designated the authority to monitor and evaluate children and families, detect 'risk' factors and notify statutory authorities accordingly (Carrington 1993).

If functional parents are able to discourage drug use in the children as suggested by Carrington (1993), it follows that children from 'dysfunctional' families are more likely than their functional counterparts to use illicit drugs. It is perhaps for this reason that the tragic death of 15-year-old schoolgirl Anna Wood had such a

shocking impact on the Australian public. Anna Wood, from Sydney's northern suburbs, died in 1995 after taking an ecstasy tablet (Dillon, Goldspink-Lord and Parkhill 1996). The representation of Anna as a 'normal', healthy Australian schoolgirl, and not a 'junkie' from Kings Cross or Cabramatta, was central to the media reports that followed her death (Dillon, Goldspink-Lord and Parkhill 1996). The published story of Anna's life and death entitled *Anna's story* quoted a medical professional as saying Anna's death was like 'a communal punch in the gut' (Donaghy 2006, p. ix). Within a short space of time after Anna's death, the 'Anna Wood Drug and Alcohol Project' had been formed with the support of the Australian Medical Association (AMA) and high rating popular television and radio media, which ensured maximum publicity to the cause. In 2007 in the New South Wales Parliament, Liberal MP, Marie Facarra, thanked Anna Wood's parents for publishing *Anna's story* and their campaigning in schools and communities to prevent young people from 'going down the dark road of drugs' (Legislative Council of New South Wales 2007).

To promote normality, health and wellbeing, and, hence, to meet social and moral obligations to produce normal children, parents in contemporary Western societies have been provided with a range of parental programs and various forms of expertise, including educational guidance (Rose 1999a, pp. 159-161). An example of the governing of children through the family is the Australian Government's *National Drug Campaign* (2011), which provides advice and guidance for parents to "discourage illicit drug use with their children". A list of 'Top 10 tips for parents' emphasises a strong family unit, healthy family relationships and a harmonious family environment in order to discourage their children from illicit drug use. In the current research, Dr Matthew described how biotechnology corporations are capitalising on parental concerns for their children's drug use by promoting and marketing parental drug testing kits to enable parents to detect drug use in their children. He refers to this consumer technology as a strategy for capitalising on fear:

> … now there is marketing of urine testing and hair testing where parents can secretly get their children's hair or urine for drug testing … people make money on this strategy and capitalise on fear. (Dr Matthew)

The parental drug testing kit[57] can be understood as a technology of parental governance that can be utilised by parents to prevent dysfunction and maladjustment in their children, the objective of which is to produce normal, healthy children. From this perspective, the family, operating as a voluntary and responsible unit for rearing and moralising children, serves governmental objectives of health and hygiene, to be achieved through an ethic in which parents are responsible for the mental and physical welfare of their children.

When Governing Does Not Work

Political discourses

Prime Minister Julia Gillard's reluctance to ease tough measures for dealing with illicit drug users due to the 'devastating consequences of drug use' (Mark Metherell *Sydney Morning Herald* 3 April 2012) is an example of how reality is represented through political discourse. Political discourse is a domain for formulating and justifying political rationalities, which not only direct the ideals or principles of governance, but also support the powers and duties of authorities, and articulate the nature of the objects governed (Rose and Miller 1992, pp. 178-179). The prime minister's political discourse of being tough on drugs illustrates how the exercise of government has become enmeshed with regimes of truth concerning the objects, processes and persons governed, and concepts of normality and pathology, danger and risk, social order and social control (Rose 1999b, pp. 29-30). During a research interview, Michael discussed how law enforcement is political, rather than focused on reducing harm associated with drug use. He also discussed the relationship between the politics of drugs and the popular media:

[57] According to Rose (2001a, p. 11) such technologies can also be understood as part of the capitalisation of truth in contemporary Western societies, which allows aspects of life that are associated with pathology to now be key opportunities for the creation of private profit. Rose (2001a, p. 37) suggests that where Foucault analysed bio-politics, we must now analyse bio-economics, because human capital is now to be understood in terms of new linkages between the politics and economics of life itself. According to Rose (2001a) psychiatric truth has become linked to a new capitalisation of treatments, as pharmaceutical companies expand drug markets. Rose (2001a, p. 11) suggests that we now have capitalisation of truth itself, as vast sums of money and research teams are required to produce biomedical truth. Health is no longer simply a biopolitical objective to ensure the wellbeing of the population, but a profit driven bio-economic goal that generates what counts for knowledge of mental disorders. Biomedicine then, is instrumental in producing knowledge of the addict, and simultaneously reshaping life by redefining and rewriting social norms through pharmaceutical drugs.

> ... for the tens of thousands of dollars it costs to bring about this operation and get a handful of pills … how can you justify that—it's just about looking like they're doing something … it just irks me you know … if it was truly about trying to change drug culture, making a difference, trying to reduce harm, I would be saying "congratulations, this is a great move". But that's not what it's about. (Michael, drug educator and researcher)

Michael used the death of Anna Wood from ecstasy as an example of how the public media shapes truths about the dangers of drugs, and subsequently determines political responses to drug use:

> Law enforcement were not interested in ecstasy, they were far more interested in the heroin market, and to some extent amphetamines. Then Anna Wood's death changed everything. And the media sort of furored afterwards … then all of a sudden there was this focus on ecstasy … the government is led by the media … not the other way around … if we have a 15-year-old, white girl who dies from ecstasy, god forbid … (Michael, drug educator and researcher)

Michael's comments illustrate how political discourse of illicit drug use produces power effects that shift the policing of one drug for another. Rose (2001a, p. 7) refers to this effect as a 'style of thought' as a way of seeing, explaining and reasoning. This is not just as a type of explanation, but about what counts as an explanation and what there is to explain; it is a way of understanding the set of problems, issues or phenomena that the explanation is attempting to account for. Styles of thought about addiction are not only a conceptualisation, rather they influence how drug users are labelled, and how they are treated within health care systems, drug services, legal systems and communities (Buchman, Illes and Reiner 2011, p. 69).

Perceptions of a failed criminal justice system

The prison

In *Discipline and Punish*, Foucault (1977a, pp. 271-272) argued that the prison, as a technology of crime control, is a failure and has been acknowledged as such since the nineteenth century. According to Foucault (1980d, pp. 39-40), the prison, in spite of being a project for the transformation of individuals, has always produced delinquency. By 1820, it was understood that prisons, far from transforming

criminals, served only to produce new criminals and drive existing ones further into criminality. From the 1830s onwards, there was a re-utilisation of the unintended negative consequence of the prison, with a new strategy of prisoners for profit (Foucault 1980f). The prison subsequently came to serve economic and political interests through the business of prostitution and the regrouping of criminals by an ex-convict police force (Foucault 1980d, pp. 41-42).

For Foucault, it is precisely the failure of the prison that has ensured the success of its continuation through a constant reform of programs and accompanying mechanisms of correction (Foucault 1977a, pp. 234-235). Hunt and Wickham (1994, p. 116) suggest that law as governance is perpetuated by its incompleteness and failure. The mutual dependence of failure and success of the prison lies within power relations because power can only ever make social machinery run incompletely or imperfectly (Hunt and Wickham 1994, p. 83). In a similar vein, Rose and Miller (1992, p. 190) argue that the government of crime is fuelled by the constant registration of 'failure', the discrepancy between objectives and outcomes, and the injunction to do better next time. It is in this context that the criminal justice approach to governing the use and supply of illicit drugs has, in spite of its failure, been continuously endorsed and promoted as an apparatus of crime control and new programs and strategies to govern drug use have been invented (Rose 1996b, p. 53). Research participants variously commented on their perceptions of a criminal justice system that has failed to meet its stated goals to prevent illicit drug use and associated harms through law enforcement. Participants also considered that the prison system had failed to rehabilitate drug users and was more likely to promote illegal drug use than prevent it. During an interview, Dr Matthew endorsed Foucault's view that prison does not prevent drug use:

> The people I know who have come out of gaol have not stopped using drugs … they've come out with the same issues and may have also changed the types of drugs they use. (Dr Matthew, medical doctor and counsellor)

Dr Matthew's view was shared by Rob and Sue, who believed that the criminal justice system encourages crime:

> The criminal justice system entrenches stigma and marginalisation of drug users. The legal status of drugs creates a criminal way of conducting drug

> business and brings people into a criminal system … the police know the war on drugs isn't working … they have no problems saying so. (Rob and Sue, health education workers)

Police officers, Ray and Jim, considered that penalisation of drug users does not succeed in preventing drug use:

> There is no answer to stopping people from using drugs … I don't think incarceration works because you can get more drugs in gaol than you can outside … (Ray, police officer)

> … My guess is that police these days recognise the futility of penalising drug addicts … (Jim, police officer)

David Garland (1990, pp. 288-289) has also argued that the prison has failed to achieve its ends of crime control, yet paradoxically its existence is sustained through crime control. He argues that most prisoners are not reformed and punishments regularly fail while the prison imposes serious deprivation and personal suffering upon those who are sent there. In spite of their admission that crime control and punishment cannot achieve their ends to eliminate or reduce drug related harms or crimes, police officers Ray and Jim are able to justify their work in drug law enforcement. Ray explained that he does his job, not because he believes in it, but because drugs are illegal and he has taken an oath to serve the police:

> You do it … not because you believe in it … whether it works or not isn't my business … the point is it's illegal … you take an oath … you're just doing your job … (Ray, police officer)

Ray's comment resonates with Rob and Sue's earlier assertion that the police know the war on drug is not working and they have no problems saying so[58]. His commitment to his policing work, despite his belief that law enforcement does not meet its objective to prevent drug use, can be understood as a game of truth. According to Foucault (1984b, p. 387), there are three fundamental elements of experience: a game of truth, relations of power, and forms of relation to oneself and

[58] Pat Carlen (2008) has referred to this apparent contradiction as 'Imaginary Penalities' which describes an adherence to institutional goals and practices while simultaneously denying their chances of success.

others. In his work, police officer Ray's policing practices are an area of political intervention encompassing all three of Foucault's fundamental elements of experience. Ray engages in games of truth that are relationships of power shaped by social institutions such as the criminal justice system. Ray upholds the law as an institutionalised truth in spite of his belief that it will not prevent illicit drug use; as such, he supports a contradictory political rationality that advocates law enforcement to 'prevent the devastating consequences of drug use' (Rose 1993, p. 288).

A quasi-criminal population?

Rose (2000) argues that crime, the prison and penalty, more generally, have become crucial elements in political rhetoric and in the government of insecurity. Prisoners overwhelmingly comprise the poor, unemployed, homeless and socially excluded, largely due to the 'war on drugs'. It is this prison population, according to Rose (2000, p. 336), that comprises a semi-permanent 'quasi-criminal' population; those who are seen as resistant to moral responsibility and whose exclusion renders them governable and blameworthy. Others have argued that prison serves as a substitute welfare service for the 'quasi-criminal' population by meeting its basic needs such as food, shelter and medical care; needs which are out of reach for this excluded population outside of prison (Comfort 2008, p. 255). According to Comfort (2008) services that used to be tied to the welfare state have, in neo-liberal society, become tied to correctional beds; hence prison has come to be seen by prisoners as a form of help available to them. The predominance of excluded populations within prisons is reflected in demographic prison population data in Chapter Three. Comments by research participants Ben and Jack illustrate how prison may serve as a substitute 'welfare' service:

> Sometimes the safest place for them is gaol … they're kicked around by the coppers, they're bashed on the streets, they're messed up ... they go to gaol and they clean up and get healthy and fit again … they get thrown out of gaol and it all begins again. (Ben, senior duty counsellor and education facilitator)

> … some kids I know like to go to detention because they get three meals a day, a bed and they can play with their mates … and [they say to me] don't get me out. (Jack, Aboriginal barrister)

Comments by Ben and Jack illustrate how prison might provide offenders experiencing extreme social deprivation with accommodation, basic health care and a means to obtain three meals a day. At the same time however, there is an expectation that the individual will accept responsibility to 'turn their life around' after prison, or face further punishment before the courts. According to Rose (1999b), within a regime of government through freedom, responsibility is assigned to the individual to achieve self-improvement, self-esteem and 'recovery'; re-offending is constructed as a choice that reflects whether or not the individual is serious about attaining sobriety and hence, is ready to turn their life around. Although the quasi-criminal population is subjected to unending forms of management and technologies of reform, upon release from prison the ex-prisoner often has very few resources to help counter the motivation for theft, drug use or other illegal activities. Thus they frequently discover the notion of turning their life around is unsustainable outside the prison gates, and they subsequently return to prison (Carlen 1983; Comfort 2008).

The failure of compulsory rehabilitation programs

Coercive strategies to address offending behaviour have been criticised on the basis that they are at odds with notions of neo-liberal freedom of choice (Seddon 2007a; Reith 2004). In the current research Ben, Louise, Dr Matthew and Lesley variously commented on a failure of compulsory rehabilitation programs:

> We get quite a few mandated types … on involuntary rehab programs in here … many don't really want to clean up ... they … have an attitude that I'll do it in spite of you … (Ben, senior duty counsellor and education facilitator).
>
> The threat of gaol doesn't stop them taking a drug … compulsory rehab doesn't work … (Louise, health education and welfare worker)
>
> … compulsory rehabilitation doesn't work … in gaol they get hero status being a rebel ... there is also a lot of power culture around drugs and you get people standing over each other for drugs ... like murder … Rehab only works if you choose it … no one can stop drug use except the person themselves. (Dr Matthew)
>
> … some people join our groups because it's part of their parole conditions or they've been ordered by the court … they are sometimes resentful and angry. (Lesley, health education and welfare worker, NSP)

These comments illustrate the failure of compulsory rehabilitation programs due to drug users' resistance and lack of willing participation. However, as was noted earlier in this chapter and in Chapter Three, the tight regimes of participation in some programs, such as urine testing, curfews and various other restrictions, can set participants up to fail. Therefore, they may be counter-productive by increasing the likelihood of non-compliance (Clancey and Howard 2006, p. 380).

Harm exacerbated by harm reduction approaches

The debate regarding the exacerbation of harm, caused by the component of law enforcement in harm reduction policies, was discussed in Chapter Three. During interviews, drug service providers, particularly advocates of safe injecting practices, commented on the tension between policy and practice resulting from the conflict between supply reduction and harm reduction. Rob and Sue commented that, while harm reduction approaches aim to reduce harm to drug users through medical responses, supply reduction through law enforcement approaches can result in further offending and keep drug users in a cycle of criminalisation:

> Harm reduction is underpinned by law enforcement but … harm reduction is a bit on the side … it's this social improvement arm … the view of the police is that if they didn't curb supply the price of drugs would fall and drugs would become more available … the other side of that is if prices were lower people would not have to commit crimes to get drugs … why do we keep people in a cycle of criminalisation when we need medical responses … (Rob and Sue, health education workers)

Lesley, a health educator and welfare worker who works within a harm reduction framework in a Needle Syringe Program (NSP) supplying clean injecting equipment to drug users considers that her professional goals to reduce harm are impeded by law enforcement:

> … having a hit is a big part of their day … you can have harm reduction but … when people spend all day getting the money and the drug and the equipment to have a hit they don't have time for anything else like finding a job … that's the product of illegality. (Lesley, health education and welfare worker, NSP)

While drug service providers acknowledged the tensions within harm reduction approaches, they were, on the other hand, strong advocates of harm reduction policies. This apparent inconsistency can be conceived as a game of truth in which harm reduction is constructed as beneficial, despite service providers' frustrations about inherent policy contradictions (Ning 2005).

Shifting drug markets

It has been argued that drug prohibition policies have achieved little in terms of preventing or reducing illicit drug use, yet since the war on drugs was declared in the 1970s there has been a proliferation of drug use and a growth in illicit drug markets (Measham and Shiner 2009; McKentin, McLaren and Kelly 2005). While the reasons for this are no doubt complex, some commentators suggest that reductions in the supply of an illicit substance stimulates the supply of new substances and provides incentives to drug users to diversify their drug use (McKentin, McLaren and Kelly 2005; McCoy 2000; Maher et al. 2007). In particular, in recent years there has been a trend in Australia and other Western nations towards the use of illicit prescription medications, such as morphine[59], stimulants and methadone (Stafford and Burns 2010). Further, there is potential for the replacement drug to cause greater physiological harm to the user than the drug it replaced. Research participants in the current research variously described this trend and the effect of shifting drug use rather than eliminating it. According to Rob and Sue:

> Most clients inject opioids … prescription opioids … have overtaken heroin use … we're following the US where there are higher death rates and addiction rates with prescribed opioids than heroin … (Rob and Sue, health education workers)

Michael attributes the changes in drug use patterns to the effects of law enforcement, and a willingness of drug users to shift their drug use according to availability:

> I think the key mistake I think we make around law enforcement is that we think if we get tough on drugs we will remove a drug from the market and all drug users will stop taking drugs and go to TAFE. You know … I mean that's

[59] This is oxycodone, which as noted in the literature review has now increased to the extent that it has become more popular than heroin use (National Drug Strategy Household Survey 2010, p. 211).

> just ludicrous. All that happens is that you make one drug difficult to access and they will find something else to replace it. And quite often over the years … Like I've been doing this for 25 years now … and quite often the drug that is the replacement does significantly more harms than the one they were using in the first place. (Michael, drug educator and researcher)

Comments by Louise, a research coordinator for a non-government alcohol and other drug organisation, also highlight how law enforcement strategies cannot eliminate drug use, but simply shift the drug of choice to other more accessible substances:

> When there's been a drug siege there tends to be an increase in the use of other types of drugs … even when the drug is totally different like heroin to ATS.[60] (Louise, research coordinator)

Ray commented that drug users do not stop using drugs just because a drug is difficult to obtain:

> They'll do what they've got access to … when there was a shortage of opium poppies in the Golden Triangle chemists got ephedra from China and hence more ATS … in remote communities it might be glue or Kava smuggled by Chinese fishermen. (Ray, police officer)

Jack commented that while there have been bans on alcohol in Aboriginal communities, there have been increases in the use of other substances:

> In NT they've brought in opal fuel to replace the unleaded ... it just gives them a headache and they still break into shops and government depots to get hold of it … in some of the more remote communities I used to see many young people return to court over and over again … since alcohol has been banned in many of those communities the next thing is more drugs … they're easy to get … not just illicit, but whatever they can get their hands on … glue … paint … walking around with a plastic bag inhaling … chroming … they're as young as ten …these problems tend to be fairly unique to Indigenous communities ... if they can't get their hands on marijuana they will get paint or glue or whatever they can. (Jack, Aboriginal barrister)

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[60] Amphetamine type stimulant.

Likewise, Tom explained that illegality is not necessarily a barrier to using harmful substances:

> It's easy to steal a bottle of rum and you're on your way … with the illegal drugs, you have to know someone … with the alcohol, it's right there and glue is just in the shop, so it's about the ease of access. (Tom, drug intervention worker)

According to these comments, there is a failure of law enforcement efforts to contain the supply or use of illicit drugs due to constantly shifting drug markets. At the same time, sustained efforts to stem the supply of drugs despite the proliferation of new substances, illustrates how attempts are constantly made to overcome the failure of government by inventing new strategies for success (Rose 1996b, p. 53). The creation of new drugs, outside systems of regulation, further confounds the likelihood of success, as argued in the next section.

Legal and natural?

The global proliferation of 'legal highs', which are also commonly referred to as 'herbal highs', and their rapid distribution to international markets through the Internet is a highly profitable enterprise. As discussed earlier in Chapter Three, these substances are legal because it is impossible for legislation to monitor and list every variant chemical as it emerges (Camelleri et al. 2010).[61] Bill described the growth in legal highs and how this has occurred:

> It appears that when young people can't get their party drugs they turn to legal highs … but herbal highs are not necessarily herbal … they are often full of chemicals … many should be tested by the TGA [Therapeutic Goods Administration] and the only reason they're legal is because they haven't been regulated yet … it's not because they're safe … many legal highs are manufactured in China and bought online … it may be illegal in some countries but legal in others so manufacturers are able to target particular international markets ... there are tons of these substances being shipped off every day …

[61] Derrida (1993) suggests that due to the difficulty in defining what a drug is 'we will always have unclassified or unclassifiable supplements of drugs or narcotics' (p. 15). He argued that there are no 'naturalistic' definitions of drugs as the concept of drugs is an instituted one that is historically and culturally contingent, and intertwined with conventions, evaluations and norms (p. 2).

> mafia groups are now involved in the marketing and manufacturing of these legal substances … the point is that regulation just simply cannot keep up with the huge expansion and increasing variety of new substances on the market. (Bill, party drugs researcher, chemist and events coordinator)

Bill described the popularity of legal highs and the notion that legal drugs are purer and safer than illegal drugs. His comments suggest that drug users may conflate legality with naturalness, purity and safety:

> The huge popularity of legal highs is due to firstly the growth of Internet trading which has opened up availability … and the legality factor … and people believe that if it's natural it's purer and better for you … Variety is another factor both because it mimics the effects and because it's different to the usual effects. (Bill, party drugs researcher and events coordinator)

Similarly, Michael argues that the notion that drug purity equates with safety is a myth. His comment opposes the views of harm reductionists (like those expressed by Rob and Sue interviewed for this study), who proposed that oxycodone pills may be safer than heroin, due to its quantifiable, regulated predictability:

> ... we've had this ridiculous line that with ecstasy you don't know what's in it … it implies that if you do know what's in it, it's ok … just because you know it's got MDMA in it doesn't mean it's ok … it's like oxycodone … one of the classic things with harm reductionists when they say … you know, if we had good stuff it would be ok … well, that's absolute crap … I mean you could die from a heroin overdose … pure heroin can kill … pure MDMA is not harmless … but this notion that the worst thing is that it's impure … is crap. (Michael, drug educator and researcher)

Comments by Bill and Michael illustrate a tendency among drug service providers and drug users to conflate legality, regulation and predictability with drug purity and safety, and illegality with harm. While illegal drug use has typically been associated with inherent harm (Manderson 1987; Royal Commission into the non-medical use of drugs, South Australia 1978), Seddon (2011a, p. 335) reminds us that misconceptions about drugs have come to be accepted as truths about drugs and drug users. These have become an integral part of how drugs and drug use are understood because their historical and political contingencies tend to be forgotten. According to

Malpas and Wickham (1995, pp. 42-43), techniques of governance can never completely grasp the objects to which their efforts are directed, nor can they control interferences or resistance; therefore, the power of government is necessarily limited and failure is inevitable. Government, then, is characterised by incompleteness and failure, and there can be no final solutions or an ultimate reform; rather, failure is an opportunity to redefine and refine techniques. From this perspective, government is productive rather than constraining because every form of governance is problematic (Malpas and Wickham 1995, p. 49). Hence, unplanned outcomes and unintended consequences are constantly emerging from efforts to govern drug use and the constant cycle of new drug creation confounds the extent to which drug markets can be governed or regulated.

Conclusion

This chapter has analysed data from drug service providers and other professionals involved in the governance of drugs to explore how drug users have come to be described, categorised and understood as a biopolitical problem, and governed to enable neo-liberal responsible citizenship. Foucault's concept of governmentality, and his empirical analysis of the problematisation of particular social groups during the nineteenth century, enables an historical perspective of the notion of the contemporary 'problem drug user'. In contemporary Western societies, the problem drug user is represented as an individual whose condition requires medical, psychiatric, legal and public health interventions. Nevertheless, the problem drug user is not defined solely on the basis of their use of particular illicit substances, but also on the basis of their social functioning in a range of areas of life. Hence, moral discourses of addiction are replaced with a more pragmatic view of addiction, which simultaneously opens up multiple possibilities for defining and governing addiction.

The shift from welfarism to neo-liberalism in the second half of the twentieth century was characterised by an emphasis of risk management and individual responsibility for individuals to self-govern to meet the objectives of government. This opened up a range of new techniques of governing drug use through the family, through self-managed hygienic practices, and through self-reflection, self-reformation and rehabilitation in sites such as the prison or rehabilitation centre. Neo-liberal

governance with its focus on responsibility has impacted profoundly on those who are socially excluded. Groups, such as Aborigines, young people who are publicly intoxicated, the homeless and unemployed people, are among those who constitute a quasi-criminal population. They may be seen as unable or unwilling to accept responsibility for their own self-improvement, despite being subjected to a range of technologies of reform. Perceptions of their inability to achieve control of their drug use or offending behaviour is constructed as a choice, and drug users can be deemed responsible for 'refusing' to change their life.

The purpose of this chapter is not to critique or confirm the reality of the characteristics of drug use or drug users, or to prescribe alternative ways of governing drug use. Rather, the chapter has explored how historically contingent representations of particular types of drug users, and the interventions prescribed for their treatment, have come to manifest as objective and unquestionable truths. Participants commented on the failure of government to meet its stated objectives to prevent the harmful consequences of illicit drug use, and the exacerbation of harm through the criminalisation of drug users. In spite of concerted efforts to contain the 'drug problem' through law enforcement and public health governance, there is little evidence of a reduction in drug supply or demand. The failure of government to meet its stated objectives is analysed as the incompleteness of governance for which there is no ultimate reform. The government of drug use through medicine, public health and the criminal justice system is expanded upon in the following chapter to understand how young people who use drugs respond to these forms of governance. Data from interviews with drug users is analysed to understand how drug use is shaped by the governance of illicit drug use, and how young people self-govern their drug use practices as practices of the self.

CHAPTER SIX: SELF-GOVERNANCE AND THE DRUG USER SELF

> … We have to study drugs. We have to experience drugs. We have to do good drugs that can produce very intense pleasure. I think this Puritanism about drugs, which implies that you can either be for drugs or against drugs, is mistaken. Drugs have now become a part of our culture … So we can't say we are "against" drugs any more than we can say we're "against" music. (Foucault 1997a, pp. 165-166)

The previous chapter explored the technologies that govern drug use and the ways in which they are made possible through contemporary knowledge, truths and political rationalities. Using interview data from drug users, this chapter answers the second research question by exploring how young people form a drug user self through the interaction of authoritative governance and their own ethical drug use practices. Research participants, aged 18-25 years, comprised 20 students and full-time employed workers[62] who used drugs they described as recreational, fun, pleasurable, and unproblematic; and nine unemployed and mostly homeless, injecting drug users[63] who described their drug use as problematic and an addiction. The chapter discusses these two groups, according to participants' self-descriptions of their drug use, in terms of the 'recreational drug user self' and the addict self[64].

The focus of the chapter is the reciprocal relationship between power, knowledge, truth and self to understand the interaction between external moral authority and drug user subjectivities in the formation of drug use practices. The first part of the chapter provides an overview of Foucault's work on games of truth as techniques by which individuals form a self. The second and third parts of the chapter explore the ways in which each drug user group experiences their drug use, and how their drug use practices form their beliefs about themselves as drug users. The fourth part of the

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[62] In the 'recreational' group of drug users were Jamie, Julian, Jim, Danny, Len, Anna, Mark, Jim, Nick, Lisa, Jenny, Cathy, Terry, Cindy, Sue, Vicki, George, June, Ted and Dave.

[63] In the 'addict' group of drug users were John, Phoenix, Roscoe, Mikki, Anne, Marie, Chris, Jeffrey and Mack.

[64] It has been noted elsewhere in this thesis that terms such as 'recreational', 'dependence' and 'addiction' are constructed and historically contingent, and therefore difficult to define. They have however been used in the thesis to describe different types of drug use as self-reported by participants.

chapter discusses how young people respond to the forms of governance discussed in Chapter Five. This enables a linking of the two research questions by illustrating how technologies of authority and technologies of the self interact in the process of governmentality. Finally, this chapter discusses the formation of the drug user self at the interplay of forms of the authority and the drug user's practices of the self.

Constituting the Self

Truth, power and the self

Foucault was concerned with games of truth and the relationship between truth, power and the self and how humans enter into games of truth to understand themselves (Kendall 2011; Foucault 1997b). He also sought to understand how humans entered into games of truth defined by knowledge, either in the form of scientific or theoretical games, or in coercive practices of institutions such as the clinic or prison (Fornet-Betancourt et al. 1987, p. 112). His work on truth, knowledge, power and the constitution of the self provides a conceptual framework for understanding how drug users form truths about themselves through scientific knowledge of drug use and through the practices of social institutions such as education systems, clinics or the criminal justice system. For example, Foucault asked what games of truth people engage in when they consider themselves to be ill, when they think of themselves as living, speaking or labouring, or when a human judges and punishes his or herself, and so on (Foucault 1985, pp. 6-7).

For Foucault, 'the self' is an experience of oneself that is historically and culturally contingent[65], and produced through a complex, interdependent system of power, knowledge and the subject (Kendall 2011; Foucault 1978). This is a process of interaction between technologies of domination and those of the self, and is what Foucault called *governmentality*. Technologies of the self do not involve a coercive practice, but rather a practice of self-formation of the subject through techniques of everyday living (Foucault 1994a; 1997b). As authorities seek to direct the individual

[65] In the same vein, Marcel Mauss (1973, p. 73) described 'techniques of the body' used in a range of societies, historical contexts and lifestyles. Mauss argues that that there is no particular identity but rather a variety of 'human' ways to use the body; the individual borrows movements which constitute them as a person, from the actions performed by others.

conduct, individuals act upon themselves through governmental-ethical practices. From this perspective, governmental practices depend upon, and operate through, the self-governing individual who forms practices of the self through a fusing of ethical and political domains (Dean 1994, p. 1995). Governmentality is also a relationship of the self to itself, encompassing practices and strategies that individuals use in their interactions with each other (Foucault 1997b, p. 300).

Ethical practices of the self

Moral codes and ethical practices

In order to understand how people form a self through games of truth, Foucault proposes two types of moral systems: one that emphasises the moral code and another that emphasises ethical practices (Rabinow 1997, p. xxvi). Ethics is concerned with the construction of a relationship with oneself, while the moral code is concerned with how the individual simply obeys a code which is external to him without any mutual or reciprocal relationship (Kendall 2011). The individual's moral conduct commits them not only to other actions in conformity with values and rules, but to a certain mode of being which constitutes self-formation as an 'ethical subject'. The individual then, becomes the object of their moral practices and acts upon his or her self to achieve their moral goal (Foucault 1985, p. 28).

Foucault conceptualised the relationship to the self or 'ethic of the self' according to four basic categories: ethical substance, mode of subjectivation, ethical work and telos. Deleuze (1988, p. 100) developed these categories as a fourfold process by which to understand self-formation as a self-constitution that derives from governing moral codes of conduct and interiorised relations with others. The first fold is the bodily or material part of ourselves, such as pleasures and desire which are connected with moral conduct; the second concerns an inversion of power upon the individual self, regulation of the self and how individuals recognise their moral obligations; the third is a folding of knowledge and its constitution of a relationship to truth, and involves self-forming activities through which one can become an ethical subject; the fourth is the fold of the outside—the ultimate fold, the kind of being to which one aspires when they behave in a moral way, of virility, truth, self-mastery and transformation. The relationship to oneself according to these four

aspects can be both interrelated and independent depending on one's goals and the kinds of techniques one uses in order to recognise and constitute the self as a subject of ethics (Foucault 1997b, pp. 263-267).

Freedom and care of the self

In the Greco-Roman world ethical practices and proper conduct were important for the achievement of freedom (Foucault 1997b, p. 284). Ethics was a conscious practice of freedom which was fundamental to not being a slave of government or of one's own passions. For the Greeks, the care of self was ethical and was understood as ethos—a way of being and of behaviour which signified freedom (Foucault 1997b, p. 286). To be free one must be respectful to oneself and others by practising an ethos of care of the self and care in relationships with others. While Foucault's (1990) account of ethics provides a framework for understanding the formation of self in relation to an ethical problem of pleasure, he was not proposing an Ancient Greek ethics for the contemporary life. Rather, he suggests, it is a question of how people could best relate to themselves and others. This requires an analysis of how individuals constitute themselves through devices, techniques, ideas, procedures and so on, as tools for attempting to understand and change the current situation (Foucault 1994e, p. 261). The following analysis of the formation of the drug user self illustrates how self-formation through ethical drug use practices takes place.

The 'Recreational' Drug User Self

Recreational fun and ethical self governance

Recreational drug users

Students and full-time workers described their drug use involving ecstasy, marijuana, LSD and amphetamines as recreational. Based on this self-description they will be referred to throughout this chapter as 'recreational' drug users. Although two participants reported having bad experiences with LSD and amphetamines that had deterred them from further use of the drugs, none of the participants described their drug use as addictive or problematic. Two students had also used 'herbal highs' as a one-off, but had experienced nausea and other unpleasant side effects. Another

student had tried magic mushrooms[66], but did not enjoy the effects and consequently had not used them again. None of the 'recreational' cohort of drug users had ever injected drugs or misused pharmaceutical drugs. Being disciplined, having temporary fun and taking responsibility were key themes that emerged from the research interviews with the group of recreational users. All participants described their drug use in terms of being quite normal, and explained they always separated their drug use from their study and working life. 'Appropriate' drug use was perceived in terms of that which did not impact on their capacity to function in everyday life, and did not interfere with long-term health, wellbeing or aspirations of future success. Julian explained that he only uses drugs in appropriate contexts with friends:

> I would never take drugs just for the sake of it … only when there are things to go to and friends that are involved. (Julian, recreational drug user)

June described her good times with ecstasy at festivals and clubs in terms of a socially acceptable form of entertainment:

> Everyone I know who goes to festivals takes ecstasy … and there's no alcohol and no violence … Big Day Out … they're just happy and nice to each other … all my girlfriends love ecstasy and love getting off their heads because it makes you so friendly … I think a lot of guys love drinking … they're just hanging around wasted, but girls … they're chopped.[67] (June, recreational drug user)

Jenny, Cathy, Terry and Nick explained that their drug use is solely for relaxation, entertainment or pleasure, and they exercise restraint by using only outside their study time:

> … the drugs I take are only when I want entertainment … raving … dance around … laugh and have fun. (Jenny, recreational drug user)

> I smoke at the end of the day … not before uni or work ... I don't want it to interfere with the important aspects of my life … I would never take ecstasy at home … only for going out … just a night time thing. (Cathy, recreational drug user)

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[66] Magic mushrooms contain a hallucinogenic chemical, psilocybin.
[67] 'Chopped' refers to experiencing the effects produced by ecstasy.

> I like to reward myself with weed after studying hard all day … (Terry, recreational drug user)
>
> I like ecstasy but I only have it when I go out to have fun ... clubbing and partying … you have heaps of energy and drink at the same time ... you're way more confident than usual and you feel really good ... the come down is pretty bad the next day ... but it's no worse than lots of alcohol. (Nick, recreational drug user)

Similarly, Sue and Cindy explained that they exercised restraint in their drug use in order to draw a distinction between their drug use and work:

> My friends and I use speed but only on weekends and at music festivals and stuff ... we're careful not to let it affect our work and will take the right amount of time off work rather than go to work scattered and stuff. (Sue, recreational drug user)
>
> Ninety percent of my friends just use for a good time and hold down jobs and be responsible. (Cindy, recreational drug user)

Ted and Vicki explained the importance of being disciplined and planning ahead in order to have fun in a way that doesn't impact on their study:

> … it's [marijuana] … a very social drug where you can pre-arrange activities … we have movies to watch, music to listen to … certain foods we buy before we do it, so we're quite prepared … I go out and drink a lot with my friends and that's a social activity … but this [smoking marijuana] is more like something I do with close friends … it's a bit different. (Ted, recreational drug user)
>
> When you take ecstasy you have to plan ahead not to work or study the next day because you feel exhausted. (Vicki, recreational drug user)

Recreational drug users self-governed their drug use pleasures, exercising ethical conduct through rational practices of restraint, austerity and discipline, acting within codes of appropriate behaviour to ensure their drug use did not impact on other aspects of their lives they considered to be important. Similarly, participants of Gourley's (2004) Australian study of ecstasy users, comprising university students and full-time workers, restricted their ecstasy use to settings conducive to the drug experience such as specific bars and clubs. They also exercised a variety of social

sanctions such as condemnation of compulsive drug use to induce an ethic of restraint among others in their group. Friends who were thought to be compulsive in their ecstasy use were excluded from the drug-using peer group. In ancient Greece, the purpose of austerity was not only to bring one's conduct into compliance with a law or rule, but to transform oneself, through care of the self, into an ethical subject of one's behaviour. While ancient Greece cannot serve as a model for prescribing behaviour or understanding contemporary drug use, it can provide a framework for understanding care of the self as an ethos for transforming oneself into a disciplined, restrained, recreational drug user (Foucault 1997b). Ethical practices are a part of forming a recreational drug user self that recognises the moral obligations according to authorities, such as education and employment, and their own moral goals and aspirations.

Responsible citizens

Normal drug use

Recreational drug users provided their views about what they thought constitutes responsible drug use. Most comments emphasised the importance of having fun responsibly, knowing one's limits, being mature and enjoying the benefits of regulated pleasure. Danny, who works in the entertainment industry, explained that his job involves preparing entertainment venues for young people using party drugs to derive maximum pleasure. Danny considers the use of party drugs such as ecstasy to be normal, socially acceptable and fundamental to his work. He explained his role in helping people who use party drugs to have fun:

> … if ecstasy didn't exist nightclubs would probably cease to exist … and if drugs in general didn't exist, techno would never have been invented … now it's more socially acceptable … it's normal to do ecstasy these days. (Danny, recreational drug user)

> In my work in rock and roll venues we provide spectacle and entertainment and enhance the atmosphere … drug use complements my job because I know what appeals to drug users ... for example too much strobe doesn't appeal to people's eyeballs when they've had ecstasy, so I limit strobe lights … (Danny, recreational drug user)

Similarly, Ted described drug use in terms of normality and popularity and explained that most of his friends use ecstasy:

> … most students use ecstasy especially if they're into the rave scene … I think it's as popular as marijuana …. most of my friends use ecstasy. (Ted, recreational drug user)

Cindy defined the meaning of responsible drug use in terms of maturity and a drug user's capacity to function at work:

> … it's only the small minority that use drugs all the time and can't work and stuff … responsible drug use comes with maturity. (Cindy, recreational drug user)

Jenny and Cathy described marijuana in terms of its benefits, and considered that their own marijuana use enhances their functionality:

> … I smoke marijuana to go to sleep … I need to have a good sleep to maintain a busy work and study routine. … there are many positive side to marijuana … like the social side … I know a lot of drama students that use marijuana for added confidence. (Jenny, recreational drug user)

> I'm a fairly wound up person … I get anxious … it calms me down … by the time I go to bed I might have had four or five cones … I have a great night's sleep … without marijuana I couldn't sleep. (Cathy, recreational drug user)

> Sometimes I'll have a couple of little cones in the morning and get into the housework and you've never seen a house cleaner … I'll make a shopping list and organise everything in my life and … wake up the next day and go "oh my gosh, that looks great". (Cathy, recreational drug user)

Minimising risk

Some of the recreational drug users explained that they like to use drugs responsibly by calculating the risks or trying to ensure the purity of their ecstasy pills. Danny and Vicki responsibly manage their drug use by conducting online research to minimise the risk of taking unsafe pills:

> I'll always test it first to make sure I'm getting it from legitimate sources ... I do my research via Bluelight, which tells you what sort of ecstasy and acid is ok and what to look out for … and erowid.org, the Wikipedia of drugs … it comes

> back to responsible use ... drug use is about responsible choice. (Danny, recreational drug user)
>
> Pill reports are a good way to know which ecstasy is good or not … like if it says "red devils have low MDMA" I'm more inclined not to buy them. (Vicki, recreational drug user)

Jenny, who constructs herself in terms of a rational, neo-liberal subject, describes her ecstasy use as fun, but is also careful to calculate and manage any risks associated with using ecstasy:

> All the risks out there … you take it as safely as possible … just take half and if you get bad effects … stop … I take an economic, rationalist view … I calculate that the return is worth the risk … it's a rational choice … a lot cheaper and more fun than alcohol … you're not standing around buying drinks … you're dancing and having fun ... and having more interesting conversations. (Jenny, recreational drug user)

These comments illustrate how recreational drug users' practise an ethos of normality, responsibility and risk management in their drug use. Fraser and Moore (2008) argue that in drug research, neo-liberal values such as autonomy, choice, employment, responsibility, rationality and prevention are typically associated with a capacity for consumption. Excessive use is regarded as irrational and subsequently stigmatised, and regulated drug use is considered to be rational and responsible. Illicit drug users are obliged to decide between claiming status as rational, neo-liberal consumers, as illustrated clearly in Jenny's comment, or to relinquish neo-liberal subjectivity and the associated responsibility, and hence risk stigmatisation (p. 744).

In this neo-liberal construction of the responsible subject, recreational drug users' subjectivity is made up through an alignment of the personal goals of the recreational drug user, and neo-liberal goals of responsibility and functionality (Cruikshank 1993). The recreational drug users shape their experience of subjectivity through the self-regulation of their conduct—through their ethical practices which are established through their practices of the self (Foucault 1985; Kelly 2006). The moral conduct of the recreational drug users, such as becoming educated and being productive, commits them not only to conformity in social values and rules, but also to a self-

formation as an ‘ethical subject’. In doing so, the individual becomes the object of their moral practices and acts upon his or her self to achieve their moral goal (Foucault 1985, p. 28).

The Addict Self

Injecting pleasures and ethical harm reduction practices

Problem or pleasure?

In contrast to the recreational drug users’ organised, rational drug use for leisure and pleasure, the group of homeless, unemployed drug users defined themselves as ‘addicts’ who used drugs on a daily basis. They also described their drug use as problematic, stressful and chaotic. Based on their self-description, this group will be referred to throughout this chapter as the addict group, however, this is not to suggest that these drug users are viewed as having a fixed identity or static drug user subjectivity. The choice of drugs of this group was generally based on availability rather than preference, however, most participants reported that they derived pleasure from injecting oxycodone on a daily basis or as often as possible. They also enjoyed heroin, marijuana, amphetamines and Xanax. Mikki and Mack explained why they enjoy using oxycodone:

> I … enjoy the feeling I get off the drug … I like the morphine … the way it just makes your body go on the nod and it relaxes all your body … like your body just goes like you’re asleep, but you’re awake … (Mikki, self-reported addict)

> I hit up the 100mg Oxycontin … I wipe the wax off the pill … put the pill in water … heat the water up … crush the fuckin’ pill up … put a filter in the water and just suck it up then inject it … you get pins and needles and an itch and then you just nod … (Mack, self-reported addict)

John loved heroin as soon as he tried it because it relieved the stresses that he had experienced for most of his life:

> ... I found heroin and it was like a god to me sort of thing. I loved it and I’d do anything for it … as soon as I tried it, that’s what I wanted to feel all the time ... like I had no worries in the world ... like I’ve stressed over a lot of things in my

> life since I was a little kid ... but when I was on heroin I didn't worry about anything, so I never wanted to come down off it … (John, self-reported addict)

Marie explained that she enjoyed smoking marijuana, injecting drugs, taking Xanax and playing the pokies after using speed.

> My favourite drug is marijuana … I've been smoking it since I was 13 … I love shooting stuff too, but it's just a different feeling … I like speed too and playing the pokies … you get so into it with all the lights and buttons … you really intensely get into it … all your money is gone, but you don't care … you just think "oh fuck it, I'm having such a good time". (Marie, self-reported addict)

> … everyone will put their hand out for a Xanax … they feel that good … (Marie, self-reported addict)

The participants' comments challenge popular notions that drug use is motivated primarily by individual or social pathology, peer pressure or dysfunctional families (McGee et al. 2009; Elkins et al. 2004). As discussed in Chapter Two, the view of drug use as pathological was developed throughout the twentieth century as liberal notions of problematic drug use became linked with irrational, compulsive (unfree) consumption, and pleasure became associated with reason and freedom (O'Malley and Valverde 2004; Fraser and Moore 2008). Pleasure in drug use subsequently become legitimised only when it was informed and calculated to allow the drug user to manage their own risk and minimise harm (O'Malley and Valverde 2004, p. 39). However, participants' comments in this research suggest that pleasure is an important motivator for participants' drug use. Further, the pleasure they derive from oxycodone tablets are related not only to the drug but also to the pleasurable effects obtained by injecting the drug. This is supported by other studies which, as mentioned in Chapter Three, have found that emotions such as fear, excitement and risk can be part of the pleasures of injecting illicit drugs (Fitzgeraldet al. 1999; Stewart 1987).

Rationalising the 'irrational'

Chapter Five discussed the liberal, rational governance of injecting drug use, and its endorsement following the discovery of HIV/AIDS, which resituated injecting drug users as self-regulating, rational subjects to be governed through technologies of

harm reduction (Walmsley 2012, p. 103). The following comments highlight how harm reduction, as an instrument of political power, functions through strategies, programs and techniques to encourage injecting drug users to engage in an ethic of responsible drug use. Themes emerging from interviews included: an ethic of responsible, self-discipline through safe injecting practices; efforts towards abstinence; efforts to improve health; and various strategies to achieve goals of rehabilitation, and social and economic participation. Most respondents stressed the importance of safe injecting drug use and were adamant that they always use clean syringes:

> I manage my drug use safely ... I use fresh needles and stuff … I don't share needles ... I don't go stupid on it. (Chris, self-reported addict)
>
> I always use clean syringes … I'm pretty pedantic about it. (Mack, self-reported addict)
>
> Safe injecting is the most important thing. (Roscoe, self-reported addict)

Anne, who had recently refrained from regular injecting drug use, felt compelled to educate others in practices of harm reduction. Those who engage in harm reduction practices are empowered to address their own problems through technologies such as drug education and self-empowerment programs, which provide drug users with the knowledge and means to self-govern their drug use (Roe 2006, pp. 245-248). It is through these everyday technologies of self-governance that the drug user self is formed and is able to govern others according to governmental rationalities. This is illustrated in Anne's comment:

> Everyone I know is on drugs of some sort and I want to be an example to them. I'm trying my best to get off the stuff ... I want to be a youth worker so I can help kids that are like I once was ... I do it now—give advice to young people … If I was to go out with some friends and inject drugs ... I'd be able to pull them up and say "hey, this is ... the safest way to do it" .... I took a course … so that I can be a peer educator about safe injecting and disposal ... all part and parcel of being a user … and I have the authority to be able to educate these people on what they're doing wrong … (Anne, self-reported addict)

Anne's aspirations of self-improvement in order to help others, illustrates how she forms an ethical self through her own moral conduct and ethical practices, and her

moral obligations to govern others in appropriate harm reduction conduct. She is, then, both governee and governor; subjecting others who she educates in harm reduction practices, while simultaneously governing herself (Kendall 2011; Foucault 1990, pp. 24, 27-29).

Neo-liberal subjects of harm reduction

Anne's commitment to educating others to reduce harm in their drug use practices includes intolerance for those who do not make the effort to exercise hygienic practices. This is illustrated in the following comment:

> … dirty injecting makes you sick—why weren't they taught how to do it properly? … I once saw a heroin junkie have a hit from an old can and he accidentally kicked dirt into it, but still shot it up ... that was so dirty ... (Anne, self-reported addict)

In her intolerance of unhygienic injecting practices, Anne is claiming status as a rational neo-liberal, responsible subject of harm reduction (Fraser and Moore 2008). The intolerance illustrated in Anne's comment was similarly noted in a study by Simmonds and Coomber (2009), which found that injecting drug users who do not engage in harm reduction practices may be constructed as 'the bottom of the heap', according to other drug users.

Jeffrey, who had recently stopped injecting drugs and was trying to stop using other drugs due to a mental health condition, was, like Anne, trying to educate other young people of the benefits of abstaining from drugs:

> … I've given up ... I've tried to convince other people ... your body isn't meant to be injecting drugs … I also try to tell people to stop smoking weed. (Jeffrey, self-reported addict)

Mikki explained that she educates less experienced drug users about safe injecting practices:

> … it's good now because I teach young ones … the bad things about drugs … having dirty shots … missing shots. (Mikki, self-reported addict)

The comments illustrate how education and counselling in harm reduction practices reproduce subjects who attribute a moral subjectivity to themselves, and aim to reform themselves according to its norms, through technologies of the self (Rose 1996c, p. 78). With their commitment to governing themselves and others, Anne, Mikki and Jeffrey act as drug user peers to educate others in safe injecting practices and assist them in their goals of ethical self-reformation. They form a drug user self through their ethical practices of responsible injecting.

Drugs as a normal survival strategy

In contrast to the 'normal' drug use of the recreational drug users, none of the addict group of drug users reported their drug use as normal in the sense of being socially or culturally normalised. Rather, most participants discussed their drug use in terms of a natural response to problems in their lives, or as a daily coping strategy under conditions that would otherwise be extremely difficult or intolerable. This included living on the street, worrying about problems relating to legal matters, or generally feeling 'hopeless' due to their economic and social exclusion. Their drug use, then, can be understood as a way of feeling or being 'normal', in spite of their abnormal circumstances. In this way, drug use was simultaneously regarded as normal and a problem, as suggested in Roscoe and Marie's comments:

> Sometimes I do drugs and drink to keep me warm on the street … when you're sober and cold and you're sitting there thinking its horrible. (Roscoe, self-reported addict)

> If you're with people on the street who are off their face and can't talk … you get a bit sick of it ... so you wanna be off your face as well … most people on the street are off their face in some form ... either drunk or smoking weed or on subie[68] … heroin … or Xanax … anything they can get their hands on. (Marie, self-reported addict)

Marie explained that many people use drugs to cope with a range of social and mental problems:

[68] Refers to Subutex, which is a trade name for buprenorphine—a synthetic opioid used to treat opioid dependence and acute pain.

> … bad things happening in your life make you wanna use … being homeless, having problems with the family ... or being unable to get a job ... it's an escape for a lot of people … those people have got problems with their friends, families ... they're homeless and have got mental problems … (Marie, self-reported addict)

Anne's drug use helped her to forget about her personal problems:

> My addiction just snowballed from social using ... it stemmed from my own personal issues ... just wanting to forget about my problems and how much I hated myself all my life ... especially being homeless; it was horrible … (Anne, self-reported addict)

For Roscoe, Marie and Anne, drug use is a condition of being homeless and is, therefore, directly related to social exclusion. Their drug use is a way of surviving the conditions of the street and enables their functioning. Conceptualising drug use as transformative provides a way of understanding it as a survival strategy for those who are homeless. The fourth of Deleuze's folds, involving transformation of the self, can be understood as young people using drugs as a way of folding inwards by transforming themselves from their homeless external material body and its street surroundings. In this conceptualisation, the first of the folds, the material body, is folded in by drug use which is the transcendent infinite fourth fold, passing between matter and the soul—the external and interior (Deleuze and Strauss 1991, p. 242). This is a way of producing a subjectivity that can transcend the crises of their homeless material world (Deleuze 1995, pp. 112-114).

In neo-liberal societies, there is an expectation that drug users take responsibility for their own conduct and its consequences, and ensure their own reformation to enable their participation in 'ethical citizenship' and membership of the moral community (Rose 1999a, p. 264; 2000, p. 335). From this perspective, illicit drug use is reformulated as a problem of self-esteem and empowerment and those who are unwilling or unable to be reformed may be managed through therapeutic or punitive technologies of governance (Rose 2000, p. 335). Similar to the nineteenth century addict with a 'disease of the will', the homeless injecting drug user is simultaneously the irrational, irresponsible subject of drug services and the rational agent of choice and autonomy.

Governing the Drug User

Delinquency and punishment

This section of the chapter provides young people's views on how government works. This follows on from the views of service providers in Chapter Five who commented on the failure of government to meet its objectives to reduce harmful drug use. In the current research, none of the 'recreational' drug users reported having contact with the criminal justice system other than some minor cannabis infringements. In contrast, a number of the addict group of drug users reported having frequent contact with the police, the courts and the prison system. Many had served at least one prison sentence resulting, either directly or indirectly, from their drug use. Two young Aboriginal men, Phoenix and Roscoe, reported that they had been incarcerated several times and were likely to return to prison in the near future:

> I've … been to gaol … for stealing for drugs, fights and public nuisance and that … my first time in prison I was 18 … and I think I'll be going back in the next few weeks or months or something ... it's a charge involving … a cop … all them coppers are always trying to find a reason to put me in gaol … (Phoenix, self-reported addict)

> … most of my crimes have been drug related ... from the start they weren't because I was just living on the street and did it to survive … since 15, most of my life has been spent in gaol … I'll be going back again soon … (Roscoe, self-reported addict)

John, who had been sentenced a number of times to juvenile detention centres and adult prisons, had recently been released on probation and was trying to abstain from using heroin:

> I've done gaol a fair few times ... because I needed money for drugs ... I've done about seven years in gaol all up, including juvy[69] … I'd get out then chop it[70] as much as I could … I knew I would get pinched sooner or later, so I'd always have heroin on me … so I could smoke a bit in the lock up. (John, self-reported addict)

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[69] Juvenile detention.
[70] Use drugs.

Comments by Phoenix, Roscoe and John highlight their vulnerability to policing and incarceration, yet, in spite of being governed through prevention and surveillance technologies such as probation and urine testing, they have returned to prison. In *Discipline and Punish*, Foucault (1977a, pp. 281-282) suggests that the roles of the police and the prison constitute an interdependent functioning system that produces delinquency, yet, at the same time, makes delinquents the targets of police surveillance. For Foucault, delinquency is produced by the system, yet, at the same time, is an instrument of it. The practices of institutions of power such as the criminal justice system are, for Foucault (1980b; 1994f), connected with social and economic processes at a given time and, as such, are constituted by knowledge and the production of truth about the delinquent drug user.

The homelessness, policing and regular periods of incarceration experienced by Phoenix, Roscoe and John are part of what Rose (2000, p. 336) describes as the criminalisation of exclusion. Those who are socially excluded are targeted by police for the violations that enable survival such as drug use, petty theft and public alcohol consumption. Judgments of groups in need of intensive policing are typically based on evaluations of normality in terms of pathology, danger and recalcitrance such as young people, Aborigines, and homeless people (Carrington 1993; Rose 1999a; Garland 2001). These judgments may be made according to assessments that are based on measures such as income, intelligence, education, emotional stability and ethnicity (Carrington 1993; Rose 1999a). Those who end up before the courts are often subjected to various forms of extra-judicial judgments that are underpinned by psychological knowledge, such as evaluation of their family life and the offender's psychological and physical condition, in order to determine judgment. Solutions to problems of excluded populations encompass a range of technologies, such as drug education, rehabilitation programs or urine testing, in order to manage those who are predominantly poor and socially marginalised (Carrington 1993; Rose 1999b; Carlen and Tombs 2006).

Extra judicial functions

As discussed in Chapter Three and Chapter Five, in Western criminal justice systems, offenders are judged, not only by the police and courts, but also through

extra-judicial functions that are embedded in the various apparatuses of the criminal justice system. None of the recreational drug users had attended drug rehabilitation programs, nor did they consider that rehabilitation was relevant to their recreational forms of drug use. However, several participants from of the addict group had attended drug rehabilitation as part of their mandatory parole or probation requirements following release from prison. Other participants had been released from prison on probation or parole, on the conditions that they abstain from using drugs and provide clean urine samples as evidence of their abstinence. Failure to complete rehabilitation programs or provide clean drug free urine samples could result in further court processes and a further period of incarceration. Chris described drug rehabilitation as unhelpful in addressing his drug use:

> I got put into rehab after gaol … it was real Christian … it was like, if you love Jesus you'll be cured ... that was the only solution … the judge sent me there … now I have to go back to gaol because I took off from rehab … the first thing I did was go for some dope. (Chris, self-reported addict)

As discussed in Chapter Two, the non-medical use of opiates was first deemed problematic during the nineteenth century, when the Society for the Suppression of Opium Trade (SSOT), based on Quaker ideology, persuaded the British public that consuming opium for other than medical purposes was an evil in the full religious sense. Addiction subsequently became understood according to a moral-pathological model, which situated the addict as an individual lacking in normal moral functioning (Harding 1986, pp. 81-82). Understandings of the addict as immoral or sick became embedded in religious, medical and political discourses and practices, and, more broadly, within popular discourse (Hickman 2004). Mutations of the Quaker ideology of the SSOT are evident in the medico-moral practices of the drug rehabilitation services described by participants. John, who was committed to abstaining from heroin, found the religious aspects of rehabilitation to be frustrating and described the rehabilitation in terms of being unhelpful to his goal not to use drugs:

> When I first got out [of gaol] I was sent to rehab … but it's just a lot of bible-bashing and it didn't work for me … they tell you Jesus will heal you … and I was like "come on, I just wanna know some ways to go into the world again and

> not use drugs" … and I don't believe in the 12 steps of NA either … I've done that ... it's a load of crap. (John, self-reported addict)

Roscoe described his experiences of a medicated drug detoxification in prison. He started attending Narcotics Anonymous in prison and continued to attend while on probation following his release. Roscoe's probation conditions included urine testing and he expected to return to prison in the near future due to a 'dirty urine' test:

> When I first went to gaol I was put in the Drug Unit … it was a three-month course ... we were all put on Valium in the morning and night … now they got me doing urines and stuff for my parole … in gaol I started doing an NA 12 steps course ... but I don't keep going because I had a [*sic*] dirty urine last week, so now I'll go back to gaol. (Roscoe, self-reported addict)

Marie considered rehabilitation to be restrictive and unhelpful, and a prison under a different name:

> ... I don't like … being denied normal things ... like being in a psyche ward or something ... very constricting … like gaol, but called treatment ... it has never worked for anyone I know … no-one gets helped. (Marie, self-reported addict)

Chris and Roscoe might be conceived as unwilling or unable to reconstruct their subjectivity in line with reformers' goals of self-empowerment and active moral citizenship (Garland 1997; Rose 1996c). According to contemporary political rationalities and technologies of government, subjects are obliged to engage in their own 'freedom' by legitimising their existence as the outcome of choices and, hence, to pursue self-fulfilment. Ethics of subjectivity are, therefore, linked to procedures of power that are tied to technologies of reformation, which are, in turn, legitimated in terms of their truth or efficacy (Rose 1996c, pp. 78-79). The 'truth' of rehabilitation and reformation achieves status due to the economic and political role it plays in separating those who violate moral responsibility by undermining the government of freedom, from those who align their personal choices with the objectives of government (Rose 2000; Rose and Miller 1992). Reformative technologies that are embedded in extra-judicial programs attempt to enable the individual to self-govern and transform themselves into citizens (Rose 1999b, pp. 271-273). The judicial system is not only concerned with coercion and punishment, but also assigns

responsibility to individuals to voluntarily consent to a form of tutelary power, such as a therapist, social worker or program for the purposes of self improvement and moral citizenship (Cruikshank 1993: 331). These technologies, therefore, assume an alignment between the offender's interests and the governing interests of authorities (Garland 1997).

Drug diversion

The decarceration movement of the 1960s in Western societies allowed for increased scrutiny of conduct, demeanour and daily activities of ex-offenders and young people. This was the effect of expansions in community corrections programs, such as community service, probation and diversion options (Carrington 1993; Rose 1999b; Garland 1985). While these forms of governance reject the notion of pathology with regard to offending behaviour, they retain the notion of the offender as deficient and in need of correction (Rose 1999b, pp. 238-239). During interviewing, a number of participants commented on their experiences of the Queensland Police Diversion Program, which they were ordered to attend after being charged with minor cannabis infringements. Some participants understood the purpose of the diversion session as educational, to help reduce harm associated with marijuana smoking, yet most participants commented that they thought it was a 'joke'. Mark and Jim commented that they were educated in the ways of safer marijuana consumption:

> … They said … keep the smoking at home … and don't do it again. They also said to use a glass bong from now on because it's cleaner. (Mark, recreational drug user)

> ... they tell you … "hey, just get a glass bong, don't smoke out of a filthy Powerade bottle and just keep it at home". (Jim, recreational drug user)

Lisa described what she considered to be humiliating, harsh, punitive treatment by the police before being referred to diversion. However, she regarded the educational aspects of drug diversion to be beneficial:

> I got caught for smoking a joint in the Valley … they took us to the station and strip searched us ... I cried ... I had to go to court three times … I had to take time off work … so silly and humiliating … then I got sent to drug diversion…

> the lady was lovely … we just watched a DVD then she recommended safer ways to smoke bongs through a bucket ... it's not being filtered by any water so you're not getting water on your lungs … like a warning and education … (Lisa, recreational drug user)

Danny, Nick and Mikki discussed the diversion session in terms of its being a joke:

> … I rocked up there stoned … most friends just turn up stoned or light up a joint as soon as they walk out the door (Danny, recreational drug user).
>
> … pretty much thought it was a joke … smoke as much as ever … videos don't stop people smoking ... not sure what the purpose was. (Nick, recreational drug user)
>
> I ended up going to drug diversion … I was smashed … everyone thought it was a joke … I didn't pay much attention. (Mikki, self-reported addict)

Anne and Mack described drug diversion in terms of being pointless or bearing little resemblance to reality:

> You go in and you watch a 2-2 ½ hour video about using drugs and how it messes your life up … it was just nice to get a bit of peace and quiet. They leave you in a room on your own and turn the lights out … it was pretty funny watching the scripted acting about using drugs ... it was like, "yeah, that doesn't happen" (Anne, self-reported addict).
>
> … I got sent to drug diversion for possession of marijuana … I went to the watch house and they gave me a notice to appear in court … I appeared two or three weeks later and the magistrate ordered drug diversion … you go and watch a video for half an hour about them saying drugs are bad and then they ask you a few questions then send you on your way … couldn't see the point in it. (Mack, self-reported addict)

The purpose of drug diversion programs, such as Queensland's Police Drug Diversion Program, is to prevent harm and encourage self-care and ethical practices in marijuana smoking. The diversion session is, therefore, a technology of governance designed to enable marijuana smokers to self-govern their marijuana use according to rationalities of public health policy and subsequently reduce drug related harm. The relationship between legal and public health authorities and young

people is a power relationship in which knowledge of hygienic practices is transmitted to young people. Foucault (1994f, pp. 292-293) described this type of pedagogical relationship as a game of strategy; a productive form of power in which domination is negotiated. The comments by the majority of participants that the diversion session was a 'joke' illustrates how resistance is part of power relationships between authority and the dominated subject (Foucault 1997). According to Foucault, the relationship between authority and subject is not simply a power relationship of domination but is mobile, reversible and unstable, and allows for a possibility of resistance of the dominated party (Foucault 1997b, p. 292). Foucault (1980) explains that government exists at the point where individuals are driven by others and the ways in which they conduct themselves. This is not a way to force people to do what the governor wants, but rather:

> … it is always a versatile equilibrium, with complementarity and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by himself. (Foucault 1993, p. 203)

For Foucault, power relations between governmental technologies and free subjects shape the self. The notion of power, here, is a complex relationship that constitutes fields of possibility that are simultaneously limiting and creative. Power, such as legislation governing drug use, does not necessarily imply a violation of the interests of drug users, but may incorporate coercion or violent force if it solidifies into states of domination (Lemke 2010). In the example of the drug diversion session, young people used strategies of resistance by regarding the session as a joke, rather than acknowledging its purpose as an educational session intended to reduce harm associated with unsafe marijuana use. Yet, Foucault (1997b, p. 292) argues that such strategies never succeed in reversing the authority; therefore, the marijuana smokers remain in a state of domination.

The Interplay of Authority and Technologies for the Self

Subjects of responsible drug use

Recreational drug users contrasted their perceptions of their own responsible drug use against what they perceived to be 'irresponsible' drug use by drug users who

inject drugs or use drugs on a daily basis. They were highly critical of those they described in terms of 'dirty junkies', in particular injecting drug users. There were also criticisms of other drug users who were perceived as dirty or 'grubby', particularly those who engaged in dirty drug use practices or failed to exercise self-control and self care in their drug use. Consistent with findings of a study by Simmonds and Coomber (2009), comments by young people illustrate that users of heroin, amphetamines and pharmaceutical drugs were regarded by recreational drug users as the lowest on the hierarchy of drug users. Danny considered that people who inject heroin deserve to be punished:

> I'm all for stamping out heroin that ruins lives … and punishing people for heroin ... I don't associate with people who use that sort of drug … only the true wasters want to stick a needle in their arm … that goes beyond human rational behaviour … (Danny, recreational drug user)

George expressed disdain for those who use drugs on a regular basis:

> People who use drugs all the time have no goals in life, no ambition, no drive … I have no respect for them … drugs can be awesome but you have to use responsibly and know your limits. (George, recreational drug user)

Jim, Julian, Sue and Vicki expressed disgust about particular types of drug users, such as injecting drug users, those who use Ice and those who smoke marijuana through a bong rather than a joint. They associated these drug use practices with certain types of people, such as disease carriers and uneducated and unsociable people:

> … my friends and I think Ice is ... grubby … the idea of injecting and the risk of HIV and Hep C ... is just too filthy … just outside the whole frame of what's pleasurable (Jim, recreational drug user).

> Methamphetamine is disgusting and dirty … the people are grubby … the sort of people who become a junkie … and … eventually start shooting up heroin … (Julian, recreational drug user)

> I think shooting up is dirty, disgusting and degrading … it shows someone is a junkie. (Sue, recreational drug user)

> ... like only bogans smoke it [marijuana] in a dirty, disgusting bong all the time and they're lazy and unemployed and stuff … or the school drop outs and

> deadshits, such as the apprentice tradies … then there's the ones that start smoking when they're at uni ... and it's more like they're the social joint smokers … there's a stigma to smoking bongs in my group … like just a fix ... not social ... just user behaviour. (Vicki, recreational drug user)

These comments illustrate how the recreational drug using subject is created in relation to others, through social norms, values and cultures. It is through various medico-moral truths about 'dirty junkies' and irresponsible drug users that recreational drug users have come to understand themselves as responsible, clean, recreational drug users, in relation to the unhygienic, irresponsible junkie (Foucault 1984c, p. 387). From this perspective, the drug user self is formed through their own culture, judgment and interactions with other individuals. Subjectivities of recreational and injecting drug users are made up through forms of knowledge, and truths that define people according to categories such as responsible, irresponsible, respectable or antisocial. Just as knowledge transforms people into certain types of people (Hacking 1986), such as disease carriers and dirty junkies, it also makes up responsible recreational drug users (O'Malley and Valverde 2004).

Subjects of drug services

Creating the addict

The notion of the diseased, pathological addict is a product of nineteenth century Europe; a personage that emerged alongside notions of 'diseases of the will' and lack of control, which made the regular use of substances a person-specific addiction (Valverde 1998; Levine 1978; Sedgwick 1992). Reinarman (2005), however, argues that the historical, political and cultural contingencies of drug use have been forgotten, as the notion of 'addiction as a disease' and the characterisation of the addict as an individual who has lost control, have come to dominate understandings of addiction as a disease. According to Sedgwick (1992, p. 582) the rapidity with which behaviour has become pathologised as an addiction, is startling[71]. She argues that what had been a question of behaviour has become a question of identities in which the drug user has been re-positioned into a narrative of decline and fatality;

[71] This is not to suggest that repetitive use of various substances do not produce a range of adverse effects that interact negatively on young people's health, lifestyles and wellbeing.

and reconstructed from an individual with relative stability and control into a pathological, impulsive, uncontrollable being.

As early as 1953, Howard Becker observed that the pleasurable effects of marijuana are not only culturally constructed but are also learned and therefore, are a pedagogical process; hence the drug per se is not the singular source of the drug effect. From Becker's perspective, motivations to use marijuana are not connected to individual dispositions as people do not have static modes of response that predetermine how they will act when they use marijuana (Becker 1953, 1963). According to Reinarman (2005, pp. 314-315), the same may be said for the notion of addiction as a disease. He argues that addicts learn the lexicon of disease from counsellors, therapists, judges, probation officers and other drug users; and are taught to form a self in terms of their lives and behaviour, according to a model of addiction-as-disease. Reinarman (2005, p. 316) considers that the physiological-pharmacological dimension of addiction has been over-emphasised and cannot sufficiently account for drug using behaviours, such as apparent 'desperate junkie' behaviour. Further, individuals' formation of their selves as out-of-control addicts may be the only way they can get access to services and, hence, the addict-self is both functional and self-reinforcing. What is important, here, is not the sort of individual the addict is, but rather, what sort of contingent, shifting and changing subjectification is at work in the construction of the addict. In the current research, all of the addict group of drug users discussed their drug use in terms of an addiction over which they had little or no control. Anne was a frequent user of drug services and commented that she needed ongoing support from services in order to sustain her psychological and emotional wellbeing and abstain from drugs:

> people like me need someone who isn't going to give up on them ... who has to be there 24/7, which is hard ... I mean I don't think there are any 24/7 services in Brisbane ... we need a lot more of them in every city. (Anne, self-reported addict)

Mikki and John described their need to use drugs every day to feel normal and to avoid being sick:

> … these days … I'm using 'cos I have to, 'cos if I don't, I'm gonna feel like shit all over again. (Mikki, self-reported addict)

> In the end I was only using heroin to be normal ... I wasn't enjoying it any more … if I didn't have it, I'd wake up sick and shaking and stuff … I think I just developed an addiction as I kept using … after a while, all I could think of was where to get the next shot. (John, self-reported addict)

Roscoe explained that although he was able to refrain from drug use in prison he began using again upon release because he was addicted:

> I didn't use many drugs in gaol because the older Aboriginal fellas there don't like the younger ones usin' drugs … I started using when I got out because I was addicted to it. (Roscoe, self-reported addict)

Similarly, Chris and John discussed their need to use drugs in terms of having an addictive personality:

> I would say I've got an addiction … I do it as many times a day as I can … I've got an addictive personality. (Chris, self-reported addict)

> Some people can go out partying and take a pill then go back to their fulltime job the next day … I couldn't do that … I just go off the rails with drugs … if you're an addictive personality, you're gonna get addicted. (John, self-reported addict)

Jeffrey viewed addiction in terms of an inevitable consequence of using drugs:

> It starts as just an experiment, then you become addicted to it. (Jeffrey, self-reported addict)

Scotty was legally prescribed oxycodone tablets for injuries sustained from a motorbike accident, but has since begun injecting the drug. He did not consider oxycodone pills to be problematic, but attributed the cause of his addiction to his practice of injecting the drug:

> I was in a bike accident and became addicted to morphine in hospital … I am legally allowed to have it because of the pain I experience from the accident … but it's the injecting that's the main cause of addiction … (Scotty, self-reported addict)

Participants' experiences of addiction can be understood as very real, lived experiences. At the same time, however, their addiction is produced and constantly reinforced by a range of drug services and technologies of therapy and rehabilitation which make them into a person with a disease or a problem (Cruikshank 1993; Keane 2002; Kelly 2013). The solution to the problem is constructed as therapy and rehabilitation to restore self-esteem and enable self-empowerment through discipline and self-governance. From this perspective, the drug addict self is created by external authority then acts upon his or her self through various technologies of subjectivity that link personal goals and desires to social order and stability, to enable participatory citizenship (Kelly 2013; Cruikshank 1993). Drug user subjectivity, then, is inseparable from the governmental objectives and the technologies that create the drug user subject. From this perspective, comments by the addict drug user group are games of truth that are embedded in social institutions and produced by the drug users' own practices of the addict self, which, in turn, constitute their subjectivity as addicts (Foucault 1977b).

The truth of addiction according to confession

As the comments above illustrate, all of the young people who described themselves as addicts believed that they were compelled to use drugs, either because they had an 'addictive personality' or an unmanageable drug habit due to the effects of the drug. These conceptualisations of themselves as addicts can be understood in terms of a self that is produced within social institutions, such as prisons and rehabilitation centres, and their associated technologies, such as counselling services and psychological therapy. Rose (1996c, pp. 96-97) argues that these technical forms of governance are a model of confession that aim to reform, empower and normalise.

Foucault's interest in the self was of the differing types of relations the self has established with itself and with others, particularly with regard to relations of power. It was also about the meanings people give to their experiences of themselves and how the self has been problematised through systems and institutions (Kendall 2011). For Foucault, subjects are produced through discourse, through a circular interdependence of power, knowledge and truth. The self, as the orator of the subject, is specific to arrangements between power and knowledge, and truth unfolds within this relationship. For Foucault (1978, p. 60), the confession is an example of the

production of truth through relations of power in which the self is produced. In this sense it is:

> … a ritual of discourse in which the speaking subject is also the subject of the statement … one does not confess without the presence … of an authority who requires the confession, prescribes and appreciate it, and intervenes in order to judge, punish, forgive, console and reconcile … (Foucault 1978, pp. 61-62)

According to Foucault (1978), the confession has been one of the main rituals for the production of truth in Western societies since at least the Middle Ages. Kendall (2011) argues that this fundamental feature of Christian culture is never erased; in secular contemporary society it lives on in domains of psychoanalysis and the general trend towards unburdening oneself through practices such as inner reflection, counselling and 'trash TV' talk shows. Foucault (1978, pp. 58-59) argues we have now become a 'confessing society' with the confession playing a part in justice, medicine, education, family relationships and so on. For Foucault, the confession is a particular form of power that identifies who one is and what one does, and hence constructs a self in terms of a norm of identity. At the same time, the confession is subjectifying; one becomes a subject by engaging in the authority of the confession (Foucault 1978; Rose 1996c). This is the 'ethics of personhood' of which the languages, techniques and types of authority do not simply direct individuals in their everyday lives, but actually play a significant role in making people up as certain kinds of selves (Rose 1997, p. 8), such as the drug addict self[72].

Aspirations for abstinence

Recreational drug users

Almost all of the recreational drug users regarded their drug use as a temporary stage of their lives that would cease once they started a career or got married and had children. Three participants thought they might continue smoking marijuana for an

[72] Young people's identification with an addict self with an uncontrollable addiction can also be understood from the perspective of 'biological citizenship', which Rose and Novas (2005) use to describe collective identity based on biological reality. Biological citizenship connects certain types of people to attitudes and notions of their biological existence, and to the social groups they belong. In this way, marginalised groups such as those diagnosed with an 'addiction' are empowered through collective identification and membership of social and cultural groups; biological citizenship is then, both individualising and collectivising (Rose and Novas 2005; Buchman, Illes and Reiner 2011).

indefinite period of time, but would not continue to use other drugs. Most participants commented that drugs were likely to interfere with a career, or it was risky or inappropriate to continue using drugs once they became parents. Jenny regarded her drug use as temporary and Ted considered that marijuana use could jeopardise his future career prospects:

> … it's quite normal … but I don't see myself using marijuana for the rest of my life … (Jenny, recreational drug user)

> … I want to practise law or something when I'm older … so I can't risk having a criminal record. (Ted, recreational drug user)

Cathy, Lisa and Sue intended to stop using drugs before they became parents as they did not want to expose their children to drugs:

> I think my smoking will fade ... I'm set on having a family ... finish uni next year … get a good job … build a house and get a car … don't want to expose my children to it. (Cathy, recreational drug user)

> The day I quit drugs is the day I discover I'm pregnant … it's the risk factor and I don't think it's worth taking the chance. (Lisa, recreational drug user)

> I wouldn't smoke pot anywhere near my children if I had any. (Sue, recreational drug user)

These comments illustrate how the recreational drug user self is formed through ethical practices and the drug user's moral goals to abstain from future drug use to prevent harm to the children or their career. Foucault's concept of care of the self provides a way of understanding the compliance of recreational drug users to moral obligations such as employment, education and family, while simultaneously practising an ethic of regulated freedom to enjoy the pleasures of drugs (Foucault 1997b).

The addict group of drug users

All of the participants from the self-reported addict group of drug users had aspirations for a future without drugs. Unlike the recreational drug users, who aspired to successful careers, families and homes, some of the addict group saw abstinence as a goal in itself. Others wanted to abstain from drugs in order to acquire

basic needs, such as accommodation and a stable existence. Mikki and Phoenix thought they could achieve abstinence if they could relocate to the country. Phoenix, who was awaiting a court case that he expected would result in a prison sentence, adopted a status of responsibility, commenting that it was up to Mikki and him to 'do the work' if they wanted to stop using drugs:

> … we were thinking of trying a country lifestyle instead of the city, because in the city … you always end up finding something ... but when it comes to the country the most you're gonna get is marijuana … I'd rather chill out at the pub and have a beer or something … or have a few cones rather than hang around the streets fuckin' chasin' dealers and other drug users around. (Mikki, self-reported addict)

> … we could stop using if me and my partner did something to get ourselves off the streets … it's not like everyone can do the work for us and that's the end of it. (Phoenix, self-reported addict)

Marie was confident that she could achieve abstinence at some time in the future:

> Further down the track I'll get off drugs ... I feel I'm someone who has the ability to do that. (Marie, self-reported addict)

Anne, whose wish was to achieve total abstinence, was happy to have found accommodation and stability in her life:

> I want better things in my life … I've got my own accommodation and I don't have to worry about where I'm sleeping at night ... I've put on weight and I eat three meals a day. (Anne, self-reported addict)

John discussed his determination to achieve abstinence and his aspiration to be a good parent to his daughter:

> … I've got naltrexone implanted into me at the moment. So it stops the receptors in my brain from getting stoned and using anything to do with opium … if I use heroin I'll get withdrawal symptoms ... the only thing that works for me is the naltrexone implant … I'm really over it, I wanna do all the things I can't do if I'm using drugs ... I don't want my little girl thinking her dad's a drug addict. (John, self-reported addict)

These comments suggest that many of the addict group of drug users see themselves as being caught in a cycle of drug use, homelessness and poverty. According to Rose (1999b, pp. 268-271), a moral obligation of citizens to govern themselves ethically is part of a politics of conduct in which problematic populations are reformulated as moral or ethical problems. Subjects are responsible for doing the work on themselves to achieve freedom and self-empowerment. This was illustrated in Phoenix's comment that he and Mikki need to take responsibility for achieving abstinence. His comment suggests that there is a conflict between his adherence to neo-liberal discourses of abstinence and the reality of his continued drug use. Although the addict group of participants experienced high levels of intervention in their lives by the criminal justice system, health workers, therapists and drug intervention workers, very few of them had been able to obtain housing or stability in their lives. Rather, in spite of being subjects of a range of responsibilising, moralising techniques of ethical reconstruction, most of these drug users had joined the ranks of the semi-permanent, quasi-criminal population (Rose 1999b, p. 270).

Subjects of moral authority

Despite participants' earlier comments to the effect that prison, rehabilitation and diversion programs are ineffective, informants were almost unanimously in favour of drug prohibition. Some participants commented that drug prohibition constrained people with addictive personalities from losing control of their drug use. Others suggested that more policing and tougher penalties could prevent harm to deter young people from using drugs, or that drug laws could be reformed or softened, but only for marijuana use.

Recreational drug users

Some participants thought that there could be a softening of drug prohibition, but only for particular types of drugs. Others believed that drug prohibition was working or that tougher penalties should be applied. Anna believed that tougher penalties and more drug education was the answer:

> Tougher penalties will work because people are put off by the thought of gaol … the system is lenient as it is ... but people should be educated about drugs when they're young. (Anna, recreational drug user)

Sue and Vicki considered that, even if drugs were legalised, addicts would commit crimes or continue to sell drugs on a black market:

> It's a good thing drugs are illegal … it's not right that people can do these drugs whenever they feel like it … if they legalised it, the world would be chaos [*sic*] … if you legalise it you're saying it's ok to use it ... so people would use a lot more … even if drugs were legal people would still do crimes to get their drugs … if they're addicts they have to feed their addiction … (Sue, recreational drug user)

> Even if drugs were legally regulated there would be junkies undercutting the legal prices … black markets would still exist. (Vicki, recreational drug user)

Ted and Nick believed that all drugs should be illegal except marijuana:

> ... drug laws are there for a reason and if there were no drug laws there would be chaos … but softer drugs like marijuana … should not be illegal. (Ted, recreational drug user)

> I don't think any other drugs except marijuana should be legalised ... ecstasy and LSD are too dangerous for the roads and stuff like that … you could be driving and just see the lights and just like ... zone out. (Nick, recreational drug user)

The addict group of drug users

Similarly, nearly all of the informants from the drug user group, in spite of their experiences of multiple prison sentences and failed attempts at rehabilitation, commented that drug legislation deterred drug use, protected individuals or prevented harm and, therefore, that all drugs should be illegal. Phoenix, Mikki, Jeffrey, John and Scotty commented that, if drugs were not prohibited, people would use more and there would be more drugs and more addiction:

> If drugs were legal it would be worse … you'd have 12 and 13-year-old kids walkin' around in alleyways, needles stickin' out of their arms … waiting for the next hit … there would be a lot more drugs around. (Phoenix, self-reported addict)

> If drugs were legal there would be … a lot more deaths … more problems … I think I'd be dead by now … drugs really stuff with you mind and body … all

> the bad stuff would be allowed … all the robbing, all the sex … (Mikki, self-reported addict)
>
> If drugs were legal it would be too crazy … it's bad enough with them being illegal … (Jeffrey, self-reported addict)
>
> It's good that drugs are illegal … they're so dangerous ... I've OD'd about six times … now I've got the date of my last OD tattooed on the back of my leg to remind myself of it every day. (John, self-reported addict)
>
> Drugs should be illegal because all the people who haven't tried it because it's illegal would come out and use if it was legal … then turn into a junkie. (Scotty, self-reported addict)

Marie, on the other hand, thought that illegality might encourage drug use by instilling a desire to use drugs:

> I think the fact that drugs are illegal makes people want them more … people will always do it … the more easy to get, the less popular they'll be. (Marie, self-reported addict)

Apparent contradictions between participants' drug use and their comments in favour of drug prohibition, and their disregard for ineffective rehabilitation and diversion programs, while condoning drug prohibition, can be understood as games of truth. On the one hand, they enjoy regulated and unregulated pleasures, yet, on the other, they discursively comply with external moral authority and claim membership of rational society despite their drug use. This suggests that drug users either retain or attempt to redeem their status as rational, neo-liberal subjects by discursively adhering to moral authority (Pennay and Moore 2010, p. 568). This can be understood to be a relationship of domination and resistance in which the dominated individual can resist authority, not by playing a game that is totally different from the game of truth, but by playing the same game differently (Foucault 1997b, p. 292).

Conclusion

This chapter has analysed data from two cohorts of drug users, aged 18 to 25 years, who are described throughout this chapter, according to their own self-definitions, as 'recreational' drug users and 'addicts'. The first group, comprising university

students and full-time workers, described themselves as part-time recreational, responsible drug users. Mostly, they used ecstasy and marijuana and regarded their drug use as 'unproblematic', as they rationally organised their drug use around their work and study and drew clear distinctions between their family and career aspirations and their drug use. The second group of drug users, comprising participants who were homeless and unemployed, described themselves as addicts and their drug use as an addiction. All were currently, or had recently been, injecting drug users who favoured oxycodone and enjoyed smoking marijuana and taking Xanax tablets. Their drug use was typically a regular or daily activity and was described as a coping strategy for extreme difficulties, such as surviving life on the street.

The use of the labels 'recreational' and 'addict' may seem to be creating a dichotomy of drug users or inventing typologies that reinforce pre-existing categories, such as 'normal' and 'dependent'. The intention of the 'labels', however, is to illustrate how participants identified themselves according to definitions imposed by moral authorities and the medical and psychological discourses of social institutions. It is through these authorities, and their technologies of governance, that drug users form recreational or addict subjectivities that shape and reinforce what they believe about themselves as drug users and how they enact these beliefs as practices of the self. The drug user self, then, is formed through the interplay of authority and drug users' own drug use practices. The self, however, is not static or fixed and addict selves can become other selves, such as an ex-drug user or peer support counsellor, as was illustrated in Anne's comments. A drug user self can also simultaneously be a rational citizen and an illicit drug user, as was illustrated in the comments by recreational drug users. There is, then, a constant negotiation of self in a relationship between power or domination, knowledge of drug use and drug users, and the drug user self. In this relationship, individuals engage in a game of truth in which they can resist and adhere to authority in an ongoing relationship of negotiation of the self.

Analysis of interview data illustrates how participants developed ethical drug use practices comprising social norms and values relating to their social and economic circumstances and experiences. The recreational drug user self is formed within ethical practices of restraint of pleasures and discipline relating to career and study

aspirations. The addict self is formed within the problematisation of addiction, which is embedded in drug services, and an ethos of disciplined, hygienic, harm reduction technologies, such as safe injecting practices. Each group of drug users had attended drug diversion for minor cannabis infringements and expressed similar views regarding its ineffectiveness. The addict drug user group had experienced multiple periods of incarceration and drug rehabilitation, both of which they reported as being ineffective. Their comments support the views of drug service providers and other professionals, in Chapter Five, that law enforcement has failed to achieve its objectives to reduce drug related harm. Paradoxically, rehabilitative technologies are underpinned by a rationalist objective to restore self-esteem and, hence, to enable self-reformation and moral citizenship. The aim is to encourage self-governance and achieve an alignment between the drug users' personal goals and governmental rationalities. Hence, drug user subjectivity is inseparable from the governmental objectives and the technologies that create the drug user subject.

CHAPTER SEVEN: CONCLUSION

This concluding chapter returns to the research aims and summarises the analysis of interview data to address the research questions. The chapter also discusses how the 'drug problem' could be reconceptualised for future drug research and policy.

Research Aims and Questions

The aim of this thesis was to understand how drugs and drug users are governed in contemporary Australian society and how drug use practices are shaped by the discourses, policies and practices of government, particularly those that are embedded in the judicial system, medicine and public health. This thesis does not propose alternative ways of governing drug use, nor does it suggest any amendments to drug policies or legislation, as to do so would be to replace one truth with another. Rather, the thesis has presented a variety of truths and deconstructed them by analysing the historical and political contingencies of illicit drug use as a problem. Through this analysis, I have sought to understand how drugs came to be a contemporary problem of crime, disease, and social and economic exclusion. The research focused on how contemporary responses to the drug 'problem' have been shaped by a complexity of historical, political, social and economic shifts and forms of expertise. In this investigation, I traced some of the key political, social and economic shifts that occurred between the nineteenth century and the twenty-first century. The thesis has also analysed the rationalities and technologies that underpin the contemporary governance of drugs and how these shape drug use practices. In order to understand the historical and political contingencies that shaped the drug problem, the research has avoided assumptions of a pre-given or pre-existing drug problem of inherently harmful chemicals, or individual or social pathology.

Since the nineteenth century the 'problem' of drug use has shaped relations with medical and judicial experts and institutions and, also, relations with the self. The practices of government have focused on biopolitical problems, such as health, disease, criminality, employment and education. This has been made possible by various governmental rationalities and technologies that are directed at managing the population through health, law and order, productivity and so on. However, the

technologies of government are not simply coercive forms of authority, but encourage drug users to self-govern their drug use in order to achieve an alignment between the drug user's personal goals and governmental rationalities. It is through this interaction of external authority and drug use practices that the drug user self is formed. This thesis has sought to understand the relationship between external governance and the drug user self through research interviews conducted with drug service providers and young people who used illicit drugs. The research questions were:

1. What are the technologies that govern drug use, and how are these made possible through contemporary knowledges, truths and political rationalities?
2. How do drug users form a drug user self through an interaction of authoritative governance and their own drug use practices?

To address the first question interviews were conducted with 15 drug service providers and other professionals from areas of drug law enforcement, drug education, and the delivery of medical care and drug services in Brisbane and Sydney. To answer the second question, interviews were conducted with 29 young people aged 18 to 25 years, in Brisbane. The sample comprised 20 participants who identified as 'recreational' drug users and nine who identified as 'addicts'. The main findings of interviews are summarised below:

What are the technologies that govern drug use, and how are they made possible through contemporary knowledges, truths and political rationalities?

Respondents' perceptions of illicit drug use

Bio-political concerns of drug users during the nineteenth century were shaped through the growth in medical knowledge and statistics. With the development of public health and epidemiology accompanying a tightening of drug regulations throughout the twentieth century, illicit drug users came to be represented as disease carriers. This understanding was reinforced following the discovery of HIV/AIDS in the 1980s and harm reduction technologies, focusing primarily on injecting drug use, were developed to manage the problem. Events coordinator, Bill, suggested that the

focus of harm reduction on injecting drug use is a political response, rather than a pragmatic one; a response that has failed to acknowledge the harms caused by drug use within the 'party scene'.

Nineteenth century problematisations of drug use focused on individual deficit relating to the 'weak will' of the user, or the 'inherent' inferior characteristics of the working classes as highlighted in Eugenics discourses. The problematisation of drug users and the subsequent proliferation of medical and psychological theories of drug use during the mid to late nineteenth century laid the foundations for the development of drug treatments and shaped twentieth century conceptions of the 'pathological addict'. Participants' comments illustrated how the contemporary addict bears a range of labels that are underpinned by notions of pathology, such as the addict with the chronic, relapsing disease, the drug user with mental health problems or the victim trapped in a cycle of necessarily addictive drugs. These are variations of medico-legal and medico-moral constructions of illicit drug use as being necessarily problematic and reflecting contemporary rationalities in treatment, policy and practice.

The broad concept of 'problem' drug use encompasses multiple possibilities for conceptualising drug users, however, drug service providers mostly described problem drug use in terms of how drug use impacts on the user's functionality. Additionally, an emphasis on functionality, as a measure of 'normal' drug use, was evident in comments made by the 'recreational' group of drug users. From this perspective, drugs are problematic insofar as they inhibit the user's potential for productivity, sociability, employment, domesticity and financial security. Making a causal connection between drug use and factors such as employment can have the effect of assigning responsibility to the individual for their lack of social participation, and implies an unwillingness of drug users to participate in citizenship.

Neo-liberal governance

Policing 'risky' populations

Neo-liberal rationalities of government justify high levels of policing of populations perceived as 'risky' or dangerous, particularly socially excluded groups, such as

young Aboriginal people, homeless people or those who are publicly intoxicated. This was evident in Jack's comments that alcohol laws in Aboriginal communities have provided police with extra 'stop and search' powers and a justification for searching Aboriginal people for drugs. Policing of risky drug using populations was also illustrated in service providers' comments that the police in Brisbane frequently search drug users leaving the Needle Syringe Program, and that police often question young people who are known, or whose families are known, to police. Risky populations are made knowable through discourses that are underpinned by governmental rationalities, such as harm reduction, law enforcement and so on. As objects of knowledge, groups, such as young people and injecting drug users, are susceptible to policing because they have come to represent problems to be solved.

Extra-judicial apparatuses

The growth in drug treatment services since the mid-twentieth century in Australia, Britain and the United States has included the development of support intervention services and the establishment of networks between institutions to address drug related crime. This networking has involved the transference of expertise in areas such as medicine, psychology, education and social work to judicial functions. These extra-judicial functions are non-legal forms of knowledge that are melded to normalising technologies, such as drug counselling and rehabilitation. During research interviews, participants described the high levels of intrusion and surveillance associated with these technologies, which can set drug users up to fail. In particular, drug offenders who are placed on probation or parole are regularly subjected to drug urine testing and those who test positive for drug use are returned to prison or further sanctioned to induce compliance.

Harm reduction rationalities and technologies

Harm reduction is underpinned by governmental rationalities concerned with promoting population health, preventing harm caused through drug related disease and crime, and the effective management of drugs and drug users. These objectives were illustrated during interviews with service providers, whose comments focused on the risks of unclean injecting equipment, the need for calculation of risks and benefits, and the need for quantifiable regularity and quality in order to reduce risk.

Treatment technologies that support harm reduction rationalities encourage autonomous consumers towards ethical responsibility and self-regulation through safe injecting and drug maintenance programs. These programs are intended to situate drug users in the realm of active citizenship by facilitating their re-engagement with social institutions, such as education, employment and so on.

Governing through the family

Shaped by nineteenth century biopolitical objectives of increasing population health, wealth and longevity, the modern family is encouraged to produce normal, adapted children who will refrain from dysfunctional behaviour, such as illegality and inebriety. Parents who use drugs can be considered unwilling or unable to fulfil their parenthood obligations and may subsequently be defined as irresponsible, and come under governmental scrutiny in ways that other parents do not. As illustrated, in a comment by Ben, that drug using parents may be characterised as having poor parenting skills and their drug use is linked to a range of other social problems, such as domestic violence, homelessness, unemployment, incarceration, mental health problems and so on. However, all parents are encouraged, through educational programs and various other forms of expertise such as counselling, to govern their children in alignment with governmental objectives to ensure that they raise healthy, active citizens.

When government does not work

A proliferation of drug use

The declaration by the UN Global Commission on Drug Policy, that the War on Drugs was a failure, was supported by key Australian stakeholders at a Roundtable in Sydney in 2012, when they called for an end to the criminalisation of drug use. Research participants' comments supported those expressed by participants of the Roundtable, stating that the criminal justice system had failed in terms of meeting its objectives to reduce harm to individuals and the community. Research participants commented that the criminalisation of drug users has not succeeded in reducing drug use, but often encourages people to use different drugs that are more harmful. Health education workers Rob and Sue commented on the higher number of drug deaths that have occurred since drug users shifted their drug use from heroin to prescribed

opioids. The tendency for young people to base their drug use on availability, rather than selective use, was identified in the literature review in Chapter Three. This was supported by participants' comments that young people are not deterred by illegality, but will use whatever drugs they can obtain, which may include substances such as glue or paint, or stealing a bottle of rum. In recent years, there has been a proliferation in the production and supply of legal 'herbal' highs through widely available sources, particularly the Internet. These legal substances have not been shown to be any less harmful than the use of illegal drugs, yet their use may be motivated by a myth that legality equates with purity and safety. This conflation of legality with safety derives, at least in part, from political discourses of illegal drug use as inherently harmful, implying that legal drug use is less harmful.

Expanding prison populations

Respondents were concerned that prison has become a home for some drug users, as it is the only place where they can obtain basic necessities, such as food and accommodation, which are otherwise out of reach. In prison, this 'quasi-criminal' population receives 'rehabilitation' and is paradoxically obliged to 'choose' self-improvement and recovery through a range of programs of reform, such as compulsory rehabilitation. However, upon release, many individuals find that there are few resources available to deter them from further drug use or other illegal activities, and they subsequently return to prison.

How do drug users form a drug user self through an interaction of authoritative governance and their own drug use practices?

The 'recreational' group of drug users

Recreational subjectivity

Students and full-time workers described their drug use as recreational, fun, normal and unproblematic. Their experience of subjectivity, as recreational drug users, was formed through an ethos of discipline, restraint and regulated fun to ensure that their drug use did not impact on their studies or work.

Rational management and regulated freedom

Most of the recreational drug user group used ecstasy to enjoy festivals, parties, clubs and other sociable activities in settings outside of their homes and work environments. They drew a clear distinction between their work and study, and their leisure and party time. They valued rational drug use and reported 'planning' to have fun by pre-arranging pleasurable activities and planning not to work or study the day after using ecstasy. Risk management was an important part of their ecstasy use and participants made efforts to minimise the risk of using unsafe 'pills' by researching relevant websites and calculating the pleasures of ecstasy against the potential risks.

Marijuana was used by some participants as a way to enhance functionality, such as having a good sleep in order to work more productively the next day, or smoking a few 'cones' as a motivation to clean the house more efficiently. The focus of the recreational drug users' calculated management was responsibility and moderation, illustrating the importance that they placed on retaining their status as neo-liberal citizens. Their ethical drug use practices interacted with their moral goals of education and productivity in the production of the recreational drug user self.

Recreational offenders

None of the 'recreational' drug user group had previously had any contact with the criminal justice system, other than orders to attend drug diversion resulting from minor cannabis offences. Despite the clear educational, harm reductionist objectives of drug diversion, almost all participants regarded the diversion program as a 'joke', or as a pointless session with an obscure meaning.

The addict group of drug users

Addict subjectivity

The participants who reported their drug use as being an addiction were homeless and unemployed, and described their drug use as chaotic, problematic, stressful and dependent. In drug literature and research, pleasurable drug use is typically associated with the use of 'recreational' party drugs, yet the 'addict' group of drug users reported that they derived a great deal of pleasure from injecting oxycodone,

smoking marijuana and taking Xanax tablets. Simultaneously, they viewed drugs as a strategy for surviving an otherwise difficult or intolerable life of homelessness and extreme poverty. Addict subjectivity was formed through discourses embedded in drug services and harm reduction rationality, with its multiple technologies of governance, such as safe drug education, social work, medical interventions and judicial functions.

Neo-liberal subjects of harm reduction

The participants' comments highlighted their commitment to ethical practices of harm reduction through safe injecting techniques and governing others to do the same. Their ethos of harm reduction was characterised by an intolerance of those who do not adhere to hygienic injecting practices and a responsibility for ensuring that other drug users learn to self-govern their drug use, in line with harm reduction rationality. In this way, the addict group of drug users were self-governing, peer educators and their drug user subjectivity was formed through their ethical practices of responsible injecting. Paradoxically, their addict subjectivity exists between the helpless addict and the autonomous, neo-liberal, harm reduction subject, who chooses to use drugs responsibly in order to minimise the risks associated with harmful drug use.

Subjects of criminal justice

The addict group of drug users reported frequent contact with the police, the courts, and the prison system for offences relating to their drug use. Participants' comments illustrated their vulnerability to policing and incarceration, and susceptibility to technologies of surveillance, such as urinalysis, which was often a requirement of their parole or probation conditions. Most participants were unable to meet these conditions and were subsequently returned to court or prison, only to reinforce their cycle of drug use, criminality and social exclusion. As noted in the literature review, these technologies of compliance greatly enhance the likelihood of non-compliance, due to their tight restrictions.

Urine testing is also a key feature of rehabilitative programs, both inside and outside of prisons, which, according to participants, were unhelpful and irrelevant due, largely, to the religious elements of the programs. Mutations of nineteenth century,

medico-moral discourses and practices are evident in the discourses and practices of the rehabilitation services described by participants. These discourses have shaped contemporary criminal justice processes and practices and are underpinned by truth claims produced by knowledge. They reflect political values and rationalities to reduce harm caused by illicit drug use, in line with biopolitical objectives of managing the health, wellbeing and productivity of the population.

Several of the addict group of drug users had attended the drug diversion program and, like the recreational drug users, regarded the program as a joke. Similar to the recreational drug users, they considered the session to be pointless and used drugs either before the session or immediately afterwards. Although the diversion session is designed to enable self-governance in line with rationalities of public health and harm reduction, both groups of drugs users demonstrated their resistance to this authority by failing to acknowledge its purpose to encourage safe marijuana smoking. The diversion program is an example of the 'apolitical' approach of harm reductionist rationality which is not directed at abstinence, but is concerned with drug users self-governing their drug use in line with safe drug use practices. At the same time, however, diversion remains within the domain the criminal justice governance. From a Foucaultian perspective the drug users are in a complementary relationship between techniques of government and practices of the self, where resistance and compliance is negotiated without ever reversing the authority.

Future aspirations

Aspiring citizens

All of the recreational drug users regarded their drug use as being a temporary stage of their lives that would, at some stage, be replaced by successful careers and domestic lives. While respondents viewed their drug use as normal, they were concerned about risks with regard to careers and future children. Several participants commented that they did not want to expose their children to drugs.

Aspirations of abstinence

All of the addict group of participants had aspirations for a future free of drugs. These aspirations were part of broader goals to escape a cycle of drug use, poverty

and homelessness. Comments were concerned with obtaining housing, achieving stability and having the ability to be a good parent. Moral obligations to take responsibility for achieving their goals were evident in participants' comments, yet there was conflict between this ideal and the reality of their circumstances.

Prohibition and drug use

Both groups of drug users commented that tougher penalties would help deter drug use. In particular, there were concerns that a softening of drug laws would encourage people to use more drugs and result in 'chaotic' drug use, irresponsible behaviour or more deaths from drugs. These comments contradicted participants' comments in which they expressed disregard for criminal justice functions, such as diversion programs, rehabilitation and incarceration. While drug users pursued the pleasures of illicit drugs, they simultaneously complied with external moral authority and discursively claimed status as rational neo-liberal subjects. These co-existing discourses are understood as a game of truth in which drug users resist domination, yet discursively adhere to authority to retain status as citizens.

The interplay of authority and technologies of the self

Subjects of responsible drug use

The self is formed through a relationship to oneself that encompasses what an individual believes about his or her self, and how they enact these beliefs as practices of the self. The recreational drug user group expressed views to the effect that their drug use was morally and socially superior to other drug users who injected drugs or engaged in drug use practices perceived to be 'grubby', irresponsible or unhygienic. Similar to middle class, nineteenth century discourses of the inherently dangerous, disease-spreading characteristics of the working classes, their comments implied that 'junkies' and other irrational types of drug users possessed inherent inferior characteristics. The recreational drug users' comments were a reflection of how particular forms of drug use and types of drug users have been problematised through a relationship between power and truth. This has brought new forms of knowledge into existence with their own particular forms of subjectivity that are linked to personages, such as the 'recreational' drug user and the 'junkie'.

The recreational drug user self

Recreational drug users formed a drug user self who valued discipline, regulated pleasure, functionality, productivity, responsibility and rationality. Pleasure was the motivation for their ecstasy and marijuana use and they defined and reinforced their recreational drug user in relation to other 'chaotic', 'addictive' forms of drug use, which they associated with uneducated, unhygienic, irresponsible, immature, undisciplined individuals. They also defined their normality and status as rational drug users through their discursive support of drug prohibition and their aspirations for a successful future career and domestic life free of drugs. The recreational drug user self exists in a seemingly contradictory position between adherence to moral authorities of education, health and lawfulness, and their pursuit of pleasure through illicit drug use. This relationship between resistance and adherence to moral authority is enacted in an ethic of regulated freedom and self-care. This relationship is not coercive, but complementary, allowing recreational drug users the freedom for resistance, through which the self is constructed by their own actions and processes.

Subjects of drug services

Most participants from the addict group of drug users believed that they had an addiction and needed to maintain their drug use on a daily basis to be 'normal' or to avoid illness. They attributed their addiction to an addictive personality or to the inevitable consequence of using addictive drugs. One young woman, Anne, believed she needed the support of drug services '24/7' in order to abstain from drug use. This thesis does not seek to question the validity of participants' lived experiences of addiction. However, participants' comments, supported by literature, suggest that experiences of addiction are inseparable from discourses of disease and dependence that are embedded in counselling, therapy, the criminal justice system and the beliefs of peer drug users. These discourses are produced and reinforced through practices and policies of drug treatments, drug services and criminal justice processes.

The drug addict self

The drug addict, therefore, does not exist in isolation, but is produced through governmental rationalities, which shape the generation of knowledge and the technologies for governing the 'drug problem'. Nor is the addict a passive subject,

rather, their addiction is an experience derived from drug services and their own drug use practices, which reinforce their beliefs of themselves as addicts. The drug addict self, then, is a product of the ways in which subjects have been problematised through social institutions and endorsed through the individual's identification and enactment of their subjectivity. Participants identifying as addicts commented on the inherent, addictive qualities of their drugs of choice and their own personal deficit as defined by an uncontrollable desire or an addictive personality. Their lived experiences as drug users were situated in problematic life circumstances, their 'disease' of addiction and their status as subjects of drug services. Their addict self was formed at the juncture of public health governance and their ethos of disciplined, hygienic, harm reduction practices, such as hygienic syringe use and safe injecting techniques.

Harm reduction is a moral imperative of responsible drug use for drug users who are considered risky, dangerous or potential disease carriers. As subjects of drug services, addicts are constructed as rational decision makers, yet, conversely, their status as an irrational addict is constantly reinforced through discourses of dependence that are embedded in drug services. Addicts undergoing pharmacotherapy treatment, such as methadone, or those participating in rehabilitative programs, are constructed as a person with a disease or a problem, thereby reinforcing the addict's need for treatments and services. Individuals' formation of their selves as out-of-control addicts may, in fact, be the only way they can get access to services and, hence, the addict-self is not only functional and self-reinforcing, but also subjectifying.

Redefining the 'Drug Problem' in Drug Policies and Research

Deconstructing 'truth'

Understanding the formation of the drug user self is important, not because it helps us to identify what sorts of people drug users are, but, rather, to understand what contingent, shifting and changing subjectification is at work in the construction of 'recreational' drug users and 'addicts'. This matters because truths, such as 'normal, recreational drug use' or 'the disease of addiction', produce knowledge about drug

use and drug users, and shape policy and practice, with some very real implications for the lived experiences of drug users. By analysing the historical and political contingencies of the drug problem, it is possible to deconstruct dominant truths and make visible the political rationalities that underpin contemporary responses to the 'problem'.

Questioning the notion of harm

According to this research, participants believed that the governing of drugs and drug users is in many respects a failure. Governing is, however, always characterised by incompleteness and failure, yet there are always opportunities to redefine and refine techniques. The reluctance of governments to concede failure or revise policy based on ambiguous notions of harm provides a starting point for reconceptualising the drug problem. The concept of harm has been central to 'get tough' law enforcement policies and the more harmful a drug is thought to be the harsher the penalties will be for its use and distribution. However, this thesis has found that, historically, there has been, and continues to be, a great deal of ambiguity regarding the harmfulness of drugs, as notions of harm tend to be historically contingent and subjective, and conflated with a range of other factors, particularly illegality. Nor is much known about how addictive many substances really are, or the extent to which, addiction is problematic to the lives of drug users.

If harm is to be prevented, it is important, firstly, to be clear about what the harm is and, secondly, to conceptualise and practice harm reduction in ways that do not exacerbate harm. This PhD research illustrated how the criminalisation of drug users can exacerbate harm, rather than reduce it. This is due partially to tight surveillance around parole, probation, diversion and drug rehabilitation, which often sets drug users up for failure. It is also due to drug law enforcement practices that primarily punish socially excluded populations, while simultaneously attempting to 'rehabilitate' and reform them to become autonomous, self-governing, functional citizens. This is unachievable for most homeless, unemployed drug users, particularly those exiting the prison system, who, in spite of their best efforts at reform, are unlikely to have access to sufficient resources to counter the motivation for crime. Failure to meet this neo-liberal ideal is constructed as fault, pathology or

deficit and can result in tighter surveillance or punishment, thereby reinforcing exclusion and increasing, rather than reducing, harm.

Re-constructing the drug user self

Harsh punitive responses to drug use can tie some drug users to a cycle of incarceration, drug services, high levels of surveillance through probation and parole conditions, failed attempts at rehabilitation and social exclusion. There is, therefore, a need for drug research to explore the implications of constructing drugs as inherently harmful and question the assumption that the regular use of some substances necessarily results in addiction. Rather than starting from pre-given assumptions of drug related harm, drug research could begin by investigating the assumptions and political rationalities underpinning problematic drug use. This would open up possibilities for policy and practice that separates the physiological effects of drugs from the harm caused by criminal justice responses, or the harm caused by the interaction of drug use with a range of social, cultural and economic circumstances.

Critical, empirical research that questions the inherent harmfulness of drugs requires consideration of the historical and political contingencies of the problem, analysis and reflection of contemporary assumptions underpinning the problematisation of drugs, and analyses of what the best responses to the problem are. This type of research is not founded on pre-conceived notions of the characteristics of drugs or drug users and does not 'reproduce the subject', nor reinforce existing knowledge for the purposes of informing policy. It is also important to analyse the subjectivities that are formed through rationalities and technologies of government, and research how drug use practices and forms of conduct are shaped within social institutions.

In drug research, the notion of normal, young people using party drugs in responsible ways for fun is counter-posed against the 'other' addicted drug user with compulsive, unhealthy habits. This neo-liberal construction of subjectivity, which represents drug users as either rational or irrational subjects, creates a false dichotomy of drug use in public discourse, policy and practice. The rational/irrational binary also allows for moral judgments to be made about the essence of drug users based on the types of drugs they use. This was evident in 'recreational' drug users' constructions of

injecting drug users as ‘filthy junkies’. These dichotomies of drug users fail to take into account the contingencies or complexities of drug use. Importantly, this has implications for what people believe about themselves and how they enact these beliefs as practices of the self. A fluid drug user self is not a fixed or static identity, such as a ‘recreational’ drug user or an ‘addict’, but is a process of fluidity and constant reconstruction of the self that allows for the formation of a range of selves rather than an essential self. It is worth considering how a different set of discourses, policies and practices might influence what the ‘addict’ group of drug users believe about their drug use and how they might react to it. In the same vein, we can reflect on how this might influence the polarised views of drug use as expressed by the ‘recreational’ group of drug users.

Bibliography

Agamben, G 1998, *Homo Sacer: Sovereign power and bare life*. Translated by Daniel Heller-Roazen, Stanford University Press, California.

Agamben, G 2005, *State of exception*, University of Chicago Press, Chicago.

Agar, M 1997, 'Ethnography: An overview', *Substance use and misuse*, vol. 32, no. 9, pp. 1155-1173.

Allen, F 1959, 'Criminal justice, legal values and the rehabilitative ideal', *The journal of criminal law, criminology and police science*, vol. 50, no. 3, pp. 226-223.

Altman, J & Hinkson, M. 2010 'Very risky business: The quest to normalize remote-living Aboriginal people', in G Marston, J Moss & J Quiggin (eds), *Risk, responsibility and the welfare state*, Melbourne University Press, Melbourne.

Anglin, M & Hser, Y 1990, 'Treatment of drug abuse', *Drugs and crime*, vol. 13, pp. 393-460.

Atkinson, P & Silverman, D 1997, 'Kundera's immortality: The interview society and the invention of the self', *Qualitative inquiry*, vol. 3, pp. 304 – 325.

Australian Bureau of Statistics 2011, *Prisoners in Australia*, cat. No. 4517.0, Australian Bureau of Statistics, Canberra. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0

Australian Drug Foundation 2011, 'Mephadrone Facts', *Drug Info*, Australian Drug Foundation, viewed 12 January, 2013. http://www.druginfo.adf.org.au/drug-facts/mephedrone

Australian Government 2011, *National Drugs Campaign*, Department of Health and Ageing: Canberra, viewed 19 November, 2012. http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/parents

Australian Institute of Criminology 2009, *Australian crime: Facts and figures*, Australian Institute of Criminology, Canberra.

Australian Institute of Health and Ageing 2010, *Sixth National HIV Strategy 2010-2013*, Publications No. 6662, Australian Institute of Health and Ageing: Canberra, viewed 1 February, 2013. http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010-hiv/$File/hiv.pdf

Australian Institute of Health and Welfare 2011, *2010 National Drug Strategy Household Survey Report*, Drug Statistics Series, Number 25, Cat. No. PHE 145. Australian Institute of Health and Welfare, Canberra, viewed 8 October, 2011. http://www.aihw.gov.au/publication-detail/?id=32212254712

Australian Institute of Health and Welfare 2012, *Alcohol and other drug treatment services in Australia 2010-11: Report on the National Minimum Data Set*, Australian Institute of Health and Welfare, Canberra, viewed 29 June, 2012. http://apo.org.au/research/alcohol-and-other-drug-treatment-services-australia-2010%E2%80%9311

Australia Legal Highs Forum 2012, *Legal High Reviews 2012*, viewed 31 July, 2012. http://www.legalhighsforum.com.au/forum.php

Australian Royal Commission of Inquiry into Drugs (Hon Justice Williams, Commissioner) 1980, *Australian Royal Commission of Inquiry into Drugs: Report*, Australian Government Publishing Service, Canberra.

Ball, J, Shaffer, J & Nurco, D 1983, 'The day-to-day criminality of heroin addicts in Baltimore – a study in the continuity of offence rates', *Drug and alcohol dependence*, vol. 12, pp. 119-142.

Barratt, M & Bright, S 2012, 'Legal highs: What should we do about synthetic cannabis?' *The Conversation*, viewed 5 January, 2013. http://theconversation.edu.au/legal-highs-what-should-we-do-about-synthetic-cannabis-10386

Barratt, M, Cakic, V & Lenton, S 2012, 'Patterns of synthetic cannabinoid use in Australia', *Drug and alcohol review*, [online version], viewed 6 January, 2013. http://www.drugfields.org.au/research-in-brief/2012/10/25/patterns-of-synthetic-cannabinoid-use-in-australia.html

Beck, U 2004, 'Risk society: Towards a new modernity', in W Scott & S Gough (eds), *Key issues in sustainable development and learning: A critical review*, Routledge Falmer London.

Becker, H 1953, 'Becoming a marijuana user', *American journal of sociology*, vol. 59, no. 3, pp. 235-242.

Becker, H 1963, Outsiders: Studies in the sociology of deviance, The Free Press, New York.

Benson, B 2009, 'Escalating the war on drugs: Causes and unintended consequences', *Stanford Law and Policy Review*, vol. 20, pp. 293-358.

Berg, B 2007, Qualitative research methods for the social sciences, 6th ed. Pearson, Boston.

Berg, B & Lune, H 2012, *Qualitative research methods for the social sciences*, 8th ed. Pearson, Boston.

Berridge, V 1979, 'Morality and medical science: Concepts of narcotic addiction in Britain 1820-1926', *Annals of science*, vol. 36, no. 1, pp. 67-85.

Berridge, V 1988, 'The origins of the English drug "scene" 1890-1930', *Medical history*, vol. 32, pp. 51-64.

Berridge, V 1992, 'Harm minimization and public health: An historical perspective', in N Heather, A Wodak, E Nadelmann & P O'Hare, *Psychoactive drugs and harm reduction: From faith to science*, Whurr Publishers, London, pp. 55-64.

Berridge, V 1999, Opium and the people: Opiate use and drug control policy in the nineteenth and early twentieth century England, Free Association Books, London.

Berridge, V & Edwards, G 1987, *Opium and the people: Opiate use in nineteenth-century England*, Yale University Press, London.

Berridge, V & Mars, S 2004, 'History of addictions', *Journal of epidemiology and community health*, vol. 58, pp. 747-750.

Bewley-Taylor, D 1999, 'The cost of containment: The Cold War and US international drug control at the UN, 1950-58', *Diplomacy and Statecraft*, vol. 10, no. 1, no. 147-171.

Blacker, CP 1937(ed), *A social problem group*?, Oxford University Press, London.

Blewett, N 1988, 'The National Campaign Against Drug Abuse: Assumption, arguments and aspirations', *The 1987 Leonard Ball Oration*, delivered at the Royal Australasian College of Surgeons, Spring Street, Melbourne on 11 March 1987, *Australian Drug and Alcohol Review*, vol. 7, pp. 191-202.

Bonnie, R & Whitebread, C 1970, 'The forbidden fruit and the tree of knowledge: An inquiry into the legal history of American marijuana prohibition', *Virginia Law Review*, vol. 56, no. 6, pp. 971-1203.

Bourgois, P 1998, 'Just another Night in a Shooting Gallery' *Theory, Culture and Society*, vol. 15, no. 2, pp. 37-66.

Brown, D, Farrier, D, Egger, S & McNamara, L 2001, *Criminal laws: Materials and commentary on criminal law and process in New South Wales*, The Federation Press, Sydney, pp. 1070-1152.

Browne, R 2009, 'Drug testing kit for kids 'ruins trust'', *Sydney Morning Herald*, 9 August, 2009, viewed June 15, 2012. http://www.smh.com.au/national/drug-testing-kit-for-kids-ruins-trust-20090808-edit.html

Buchman, D, Illes, J & Reiner, P 2011, 'The paradox of addiction neuroscience', *Neuroscience*, vol. 4, no. 2, pp. 65-77.

Bull, M 2003, *Just treatment: A review of international programs for the diversion of drug related offenders from the criminal justice system*. A report prepared for the Department of the Premier and Cabinet, Queensland, Queensland University of Technology, Brisbane.

Bull, M 2008, *Governing the heroin trade: From treaties to treatment*, Ashgate, Aldershot.

Bull, M 2010, *Punishment and sentencing: Risk, rehabilitation and restitution*, Oxford University Press, Melbourne.

Burchell, G 1993, 'Liberal government and techniques of the self', *Economy and Society*, vol. 22, no.3, pp. 267-282.

Burchell, G 1996, 'Liberal government and techniques of the self', in A. Barry, T. Osborne, and N. Rose (eds), *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, UCL Press, London, pp. 19-36.

Camilleri, A, Johnston, M, Brennan, M., Davis, S & Caldicott, D 2010, 'Chemical analysis of four capsules containing the controlled substance analogues 4-methylmethcathinone, 2-flueormethamphetmine, a-phthalimidopropiophenone and N-ethylcathinone', *Forensic science international*, vol. 197, pp. 59-66.

Canguilhem, G 1991, *The normal and the pathological*, Zone books, New York.

Cannon, M 1976, *Life in the cities*. Australia in the Victorian Age: 3. Thomas Nelson, Melbourne.

Carlen, P 1983, *Women's Imprisonment: A Study in Social Control*, Routledge & Kegan Paul, London.

Carlen, P 1998, *Sledgehammer: Women's Imprisonment at the Millennium*, Macmillan Press, London.

Carlen, P (ed.) (2008), *Imaginary Penalities*, Willan Publishing, Devon.

Carlen, P &Tombs, J 2006, 'Reconfigurations of penality: The ongoing case of women's imprisonment', *Theoretical Criminology*, vol. 10, no. 3, pp. 337-361.

Carney, T 1987, *Drug Users and the Law in Australia: From Crime Control to Welfare*, The Law Book Company Limited, Sydney.

Carrington, K 1993, *Offending girls: Sex, youth and justice*. Allen and Unwin, Sydney.

Carrington, K 2006, 'Does feminism spoil girls? Explanations for official rises in female delinquency', Australian and New Zealand Journal of Criminology, vol. 39, no. 1, pp. 34-53.

Carrington, K & Pereira, M 2009, *Offending youth: Sex, crime and justice*, The Federation Press, Sydney.

Castel, R 1991, 'From dangerousness to risk' in G. Burchell, C. Gordon and P. Miller (eds), *The Foucault Effect*, Harvester Wheatsheaf, London, pp. 281-298.

Chandler, R, Fletcher, B & Volkow, N 2009, 'Treating drug abuse and addiction in the criminal justice system: Improving public health and safety', *Journal of the American Medical Association*, vol. 301, pp. 193-190.

Cherubin, C 1967, 'The medical sequelae of narcotic addiction', *Annals of Internal Medicine*, vol. 67, no. 1, pp. 23-33.

Cho, J & Trent, A 2006, 'Validity in qualitative research revisited', *Qualitative research*, vol. 6, no. 3, pp. 319-340.

Clancey, G & Howard, J 2006, 'Diversion and criminal justice drug treatment: Mechanism of emancipation or social control', *Drug and alcohol review*, vol. 25, pp. 377-385.

Cloward, R & Ohlin, L 1960, *Delinquency and opportunity: A theory of delinquent gangs*, Free Press, Glencoe.

Cohen, A 1955, *Delinquent boys*, The Free Press, New York.

Cohen, P 2000, 'Is the addiction doctor the voodoo priest of western man,'? *Addiction, research and theory*, vol. 8, no. 6, pp. 589-598.

Cohen, S 1972, *Fold devils and moral panics*, MacGibbon and Kee, London.

Cohen, S 1979, 'The punitive city: Notes on the dispersal of social control', *Crime, law and social change*, vol. 3, no. 4, pp. 339-363.

Comfort, M 2008, 'The best seven years I could'a done': The reconstruction of imprisonment as rehabilitation', in P. Carlen (ed) *Imaginary Penalities*, Willan Publishing, Devon.

Commonwealth of Australia 2010, *Sixth National HIV Strategy 2010-2013*. Commonwealth Department of Health and Ageing, Canberra viewed February 16, 2013. http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010-hiv/$File/hiv.pdf

Coomber, R & Sutton, C 2006, 'How quick to heroin dependence', *Drug and alcohol review*, vol. 25, no. 5, pp. 463-471.

Council of Australian Governments (COAG) 1999, *Special Council of Australian Governments' Meeting 9 April, 1999: Communique*, Council of Australian Governments, Canberra, viewed December 5, 2011. http://www.coag.gov.au/coag_meeting_outcomes/1999-04-09/index.cfm

Courtwright, D 1982, *Dark paradise: Opiate addiction in America before 1940*, Harvard University Press, Cambridge.

Courtwright, D 2005, 'Mr ATOD's wild ride: What do alcohol, tobacco, and other drugs have in common?' *The social history of alcohol and drugs*, vol. 20, pp. 105-140.

Cowlishaw, G 2004, *Blackfellas, whitefellas, and the hidden injuries of race*, Blackwell, Oxford.

Crime and Misconduct Commission 2008, *Mandatory treatment and perceptions of treatment effectiveness: A Queensland study of non-custodial offenders with drug and/or alcohol abuse problems*, Research and Issues Paper Series, number 7, October 2008, Crime and Misconduct Commission, Brisbane.

Cruikshank, B 1993, 'Revolutions within: Self-government and self-esteem', in A Barry, T Osborne & N Rose, *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, UCL Press, London, pp. 231 - 252.

Cunneen, C 2008, *Reflections on criminal justice policy since the Royal Commission into Aboriginal Deaths in Custody*, University of New South Wales Faculty of Law Research Series 2008 (Working Paper 7), viewed March 25, 2011. www.austlii.edu.au/au/journals/UNSWLRS/2008/7.html

Dauda, C 2010, 'Childhood, age of consent and moral regulation in Canada and the UK', *Contemporary Politics*, vol. 16, no. 3, pp. 227-247.

Davies, J 1997, *The myth of addiction*, 2nd edn, Harwood, Amsterdam.

Davis, F & Munoz, L 1968, 'Heads and freaks: Patterns and meanings of drug use among hippies', *Journal of health and social behaviour*, vol. 9, no. 2, pp. 156-164.

Day, D 1988, 'Aliens in a hostile land a re-appraisal of Australian history', *Journal of Australian studies*, vol. 12, no. 23, pp. 3-15.

Dean, M 1994, *Critical and effective histories: Foucault's methods and historical sociology*, Routledge, London.

Dean, M 1995, 'Governing the unemployed self in an active society', *Economy and Society*, vol. 24, no. 4, pp. 559-583.

Dean, M 1996, 'Foucault, government and the enfolding of authority', in A Barry, T Osborne & N Rose (eds.), *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, UCL Press, London, pp. 209-230.

Dean, M 1999, Governmentality: Power and rule in modern society, Sage Publications, London.

Dean, M & Hindess, B 1998 (eds), *Governing Australia*. Cambridge University Press, Melbourne.

Deleuze, G 1988, *Foucault*, University of Minneapolis Press, Minneapolis.

Deleuze, G 1995, *Negotiations, 1972-1990*, Columbia University Press, New York.

Deleuze, G & Strauss, J 1991, 'Baroque topographies: Literature/History/Philosophy', *Yale French Studies*, no. 80, pp. 227-247.

Denzin, N & Lincoln, Y 1994 (eds.), *Handbook of qualitative research*, 2nd edn, Sage, California.

Denzin, N & Lincoln, Y 2011 (eds), 'Introduction: The discipline and practice of qualitative research', *The Sage handbook of qualitative research*, 4th edn. Sage, Los Angeles.

Departmental Committee on Morphine and Heroin Addiction 1926, *Departmental Committee on Morphine and Heroin Addiction (Rolleston) 1926*, Her Majesty's Stationery Office, London, viewed November 1, 2012. http://www.druglibrary.eu/library/reports/rolleston.pdf

Des Jarlais, D & Friedman, S 1993, 'AIDS, injecting drug use and harm reduction', in N Heather, A Wodak, E Nadelmann & P O'Hare (eds.), *Psychoactive drugs and harm reduction: From faith to science*, Whurr Publishers, London.

Dillon, P, Goldspink-Lord & Parkhill, N 1996, 'Sex, drugs and just say no: A media perspective', *International Journal of Drug Policy*, vol. 7, no. 3, pp. 183-186.

Dive, R., Killen, M., Cole, D & Poder, A 2003, 'New South Wales Youth Drug Court', Paper presented at the Australian Institute of Criminology in conjunction with the New South Wales Department of Juvenile Justice Conference, *Juvenile Justice: From Lessons of the Past to a Road Map for the Future*, Sydney, 1-2 December, 2003.

Dolan, K., MacDonald, M, Silins, E & Topp, L 2005, *Needle and syringe programs: A review of the evidence*, Department of Health and Ageing, Canberra.

Dole, V & Nyswander, M 1967, 'Heroin addiction – a metabolic disease', *Archives of internal medicine*, vol. 120, pp. 19-24.

Donaghy, B 2006, *Anna's story*, Harper Collins, Sydney.

Donzelot, J 1979, *The policing of families*. Hutchinson, London.

Douglas, B & McDonald, D 2012, *The prohibition of illicit drugs is killing and criminalizing our children and we are letting it happen*, Report of high level Australia21 Roundtable at the University of Sydney, Tuesday 31st January 2012, Australia21, Sydney, viewed July 14, 2012. http://www.australia21.org.au//publications/press_releases/Australia21_Illicit_Drug_Policy_Report.pdf

Drabsch, T 2006, *Crystal methamphetamine use in New South Wales*, Briefing Paper no. 19/06, NSW Parliamentary Library Research Service, Sydney, viewed May 17, 2009. http://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/0/c4f93886027fd310ca25723c001355a4/$FILE/CrystalMeth%20and%20Index.pdf

Dreyfus, H & Rabinow, P 1982, *Beyond structuralism and hermaneutics*, Harvester, Brighton.

Drury, H 1899, 'Morphinomania', *The Dublin Journal of Medicine*, vol. 107, pp. 321-344.

Duff, C 2005, 'Party drugs and party people: examining the 'normalization' of recreational drug use in Melbourne, Australia', *International Journal of Drug Policy*, vol. 16, pp. 161–170.

Duff, C 2007, 'The pleasure in context', *International journal of drug policy*, vol. 19, pp. 384-392.

DuPont, R 2002, 'Heroin addiction in the nation's capital, 1966-1973', in D Musto (ed.), *One hundred years of heroin*, Auburn House, London.

Eardley, T, McNab, J, Fisher, K, Kozlina, S, Eccles, J & Flick, M 2004, *Evaluation of the New South Wales Youth Drug Court Pilot Program*, Final Report for the New South Wales Attorney-General's Department, University of New South Wales, Sydney.

Elias, N 1983, *The court society*, Basil Blackwell, Oxford.

Elias, N 1994, *The civilizing process: History of manner and state formation and civilization*, Basil Blackwell, Oxford.

Elkins, I., McGue, M, Malone, S & Iacono, W 2004, 'The effect of parental alcohol and drug disorders on adolescent personality', *The American journal of Psychiatry*, vol. 161, no. 4, pp. 670-676.

Ewald, F 1991, 'Insurance and risk', in G. Burchell, C. Gordon and P. Miller (eds.), *The Foucault Effect*, Harvester Wheatsheaf, London, pp. 197-210.

Finch, L 1999, 'Soothing syrups and teething powders: Regulating proprietary drugs in Australia, 1860-1910', *Medical history*, vol. 43, pp. 74-94.

Fitzgerald, J, Louie, R, Rosenthal, D & Crofts, N 1999, 'The Meaning of the Rush for Initiates to Injecting Drug Use', *Contemporary Drug Problems*, vol. 26, no. 3, pp. 481-504.

Fornet-Betancourt, R, Becker, H, Gomez-Muller, A & Gauthier, J 1987, 'The ethic of care for the self as a practice of freedom: An interview with Michel Foucault on January 20, 1984', *Philosophy and social criticism*, vol. 12, pp. 112-131.

Foucault, M 1970, *The order of things: An archeology of the human sciences*, Pantheon, New York.

Foucault, M 1977a, *Discipline and punish: The birth of the prison*. Penguin, London.

Foucault, M 1977b, 'The political function of the intellectual', *Radical philosophy*, vol. 17, pp. 13-14.

Foucault, M 1978, *The history of sexuality, Volume 1: An introduction*, translated by Robert Hurley, Penguin, London.

Foucault, M 1980*a*, Tru*th and Subjectivity*, Howison Lectures, October 20-21, 1980, Media Resources Centre, University of California, Berkeley, viewed August 8, 2011. http://www.lib.berkeley.edu/MRC/foucault/howison.html

Foucault, M 1980*b*, 'Two lectures', in C Gordon (ed.), *Power/Knowledge: Selected interviews and other writings 1972-1977*, Harvester Wheatsheaf, Hertfordshire, pp. 78-108.

Foucault, M 1980*c*, 'The politics of health in the eighteenth century', in C. Gordon (ed.), *Power/Knowledge: Selected interviews and other writings 1972-1977*, Harvester Wheatsheaf, Hertfordshire, pp. 166-182.

Foucault, M 1980*d*, 'Prison talk', in C Gordon (ed.), *Power/Knowledge: Selected interviews and other writings 1972-1977*, Harvester Wheatsheaf, Hertfordshire, pp. 37-62.

Foucault, M 1980*e*, 'Truth and power', in C Gordon (ed.), *Power/Knowledge: Selected interviews and other writings 1972-1977*, Harvester Wheatsheaf, Hertfordshire, pp. 107-133.

Foucault, M 1980*f*, 'The confession of the flesh', in C Gordon (ed.), *Power/Knowledge: Selected interviews and other writings 1972-1977*, Harvester Wheatsheaf, Hertfordshire, pp. 194-228.

Foucault, M 1984*a*, 'On the Genealogy of Ethics: An overview of work in progress', in P Rabinow (ed.), *The Foucault Reader*, Penguin, London.

Foucault, M 1984*b*, 'Politics and ethics: An interview', in P Rabinow (ed.), *The Foucault Reader*, Penguin, London.

Foucault, M 1984*c*, 'Polemics, politics and problematizations: An interview', in P Rabinow (ed.), *The Foucault Reader*, Penguin, London, pp. 381-390.

Foucault, M 1984*d*, *The history of sexuality: Volume 3: The care of the self*, translated by Robert Hurley, Penguin Books, London.

Foucault, M 1984*e*, 'Nietzsche, genealogy, history', in P Rabinow (ed.), *The Foucault reader*, Pantheon, New York, pp. 76-100.

Foucault, M 1985, *The history of Sexuality: Volume 2: The use of pleasure*, translated by Robert Hurley, Random House, New York.

Foucault, M 1988*a*, 'Truth, power and self: An interview with Michel Foucault, October 25, 1982' with Rux Martin, in L Martin, H Gutman & P Hutton (eds.), *Technologies of the Self: A seminar with Michel Foucault*, Tavistock, London, pp. 9-15.

Foucault, M 1988b, *Madness and civilization: A history of insanity in the age of reason* translated by Richard Howard, Vintage Books, New York.

Foucault, M 1990, *The use of pleasure: Volume 2 of The History of Sexuality*, translated by Robert Hurley, Vintage Books, New York.

Foucault, M 1991*a*, 'Governmentality', in G Burchell, C Gordon & P Miller, *The Foucault Effect*, Harvester Wheatsheaf, London, pp. 87-104.

Foucault, M 1991*b*, 'Questions of method' in G Burchell, C Gordon and P Miller, *The Foucault Effect*, Harvester Wheatsheaf, London, pp. 73-86.

Foucault, M 1993, 'About the beginning of the hermeneutics of the self: Two lectures at Dartmouth', *Political theory*, vol. 21, no. 2, pp. 198-227.

Foucault, M 1994*a*, 'Polemics, politics and problematizations: an interview with Michel Foucault', in P Rabinow & N Rose (eds.), *The essential Foucault: Selections from the essential works of Foucault 1954-1984*, The New Press, New York, pp. 18-24.

Foucault, M 1994*b*, 'Technologies of the self', in P Rabinow & N Rose (eds.), *The essential Foucault: Selections from the essential works of Foucault 1954-1984*, The New Press, New York, pp. 145-169.

Foucault, M 1994*c*, 'The birth of biopolitics', in P Rabinow & N Rose (eds.), *The essential Foucault: Selections from the essential works of Foucault 1954-1984*, The New Press, New York, pp. 202-207.

Foucault, M 1994*d*, *The birth of the clinic: An archaeology of medical perception*, translated from the French by AM Sheridan Smith, Vintage Books, New York.

Foucault, M 1994*e*, 'On the genealogy of ethics: An overview of work in progress', in P Rabinow & N Rose (eds.), *The essential Foucault: Selections from the essential works of Foucault 1954-1984*, The New Press, New York, pp. 253-280.

Foucault, M 1994f, 'The ethics of the concern of the self as a practice of freedom', in P Rabinow & N Rose (eds.), *The essential Foucault: Selections from the essential works of Foucault 1954-1984*, The New Press, New York, pp. 281-301.

Foucault, M 1994g, 'Truth and power', in J Faubion (ed.), *Power: Essential works of Foucault 1954-1954*, translated by Robert Hurley and others, The New York Press, New York, pp. 111-133.

Foucault, M 1997*a*, 'Sex, power, and the politics of identity', in P Rabinow (eds), M Foucault, *Ethics, subjectivity and truth: The essential works of Michel Foucault 1954-1984*, volume one, The New Press, New York, pp. 163-174.

Foucault, M 1997*b*, 'The ethics of the concern for Self as a practice of freedom', in P Rabinow (ed.), M Foucault, *Ethics, subjectivity and truth*: *The essential works of Michel Foucault 1954-1984*, volume one, The New Press, New York, pp. 281-302.

Foucault, M 2003*a*, *Abnormal: Lectures at the College de France 1974-1975*, translated by Graham Burchell, Palgrave, New York.

Foucault, M 2003*b*, *Society must be defended: Lectures at the College de France 1975-1976*, Picador, New York.

Foucault, M 2008*a*, *The government of self and others*: *Lectures at the College de France 1982-1983*, Palgrave, London.

Foucault, M 2008*b*, *The birth of biopolitics: Lectures at the College de France 1978-79*, translated by Graham Burchell, Palgrave, New York.

Frankfort-Nachmias, C & Nachmias, D 1996, *Research methods in the social sciences*, 5th edn, Arnold, London.

Fraser, S 2011, 'Beyond the 'potsherd': The role of injecting drug use-related stigma in shaping hepatitis C', in S Fraser & D. Moore (eds.), *The drug effect: Health, crime and society*, Cambridge University Press, Melbourne.

Fraser, S & Moore, D 2008, 'Dazzled by unity? Order and chaos in public discourse on illicit drug use', *Social science and medicine*, vol. 66, pp. 740-752.

Fraser, S & Valentine, K 2008, *Substance and substitution: Methadone subjects in liberal societies*, Palgrave, Hampshire.

Gale, F & Wundersitz, J 1989, 'The operation of hidden prejudice in pre-court procedures: The case of Australian Aboriginal youth, *The Australian and New Zealand journal of criminology*, vol. 22, pp. 1-22.

Garland, D 1985, *Punishment and welfare: A history of penal strategies*, Gower, Aldershot.

Garland, D 1990, 'Frameworks of inquiry in the sociology of punishment', *The British Journal of Sociology*, vol. 14, no. 1, pp. 1-15.

Garland, D 1997, ''Governmentality' and the Problem of Crime: Foucault, Criminology, Sociology', *Theoretical Criminology*, vol. 1, no. 2, pp. 173-214.

Garland, D 1999 ''Governmentality' and the Problem of Crime' in R Smandych (ed.), *Governable Places: Readings on Governmentality and Crime Control*, Ashgate, Aldershot, pp. 15-43.

Garland, D 2001, *The culture of control*, University of Chicago Press, Chicago.

Gay, G, Senay, E & Newmeyer, J 1974, 'The pseudo junkie: Evolution of the heroin lifestyle in the non-addicted individual', *Anesthesia and analgesia*, vol. 53, no. 2, pp. 241-247.

Global Commission on Drug Policy 2011, *War on Drugs: Report of the Global Commission on Drug Policy*, Global commission on Drug Policy, Rio de Janeiro, viewed July 29, 2012. http://www.globalcommissionondrugs.org/reports

Goetz, B & Mitchell, T 2006, 'Pre-arrest/booking drug control strategies: Diversion to treatment, harm reduction and police involvement', *Contemporary drug problems*, vol. 33, pp. 473-520.

Gordon, C 1991, 'Governmental rationality: an introduction', in G Burchell, C Gordon & P Miller (eds.), *The Foucault Effect: Studies in Governmental Rationality*, Harvester Wheatsheaf, London, pp. 1-51.

Gourley, M 2004, 'A subcultural study of recreational ecstasy use', *Journal of sociology*, vol. 40, no. 1, pp. 59-73.

Government of Western Australia 2010, *Offender drug and alcohol strategy 2010-2014: Making a positive difference*, Government of Western Australia, Department of Corrective Services, Perth, viewed April 5, 2012. http://www.correctiveservices.wa.gov.au/_files/rehabilitation-services/drug-strategy.pdf

Grapendaal, M, Leuw, E & Nelen, H 1992, 'Drugs and Crime in an Accommodating Social Context: the Situation in Amsterdam', *Contemporary Drug Problems*, pp. 303-326.

Hacking, I 1981, 'Lakatos's philosophy of science', in I Hacking (ed.), *Scientific revolutions*. Oxford University Press, Oxford.

Hacking, I 1986, 'Making up people', in T Heller, M Sosna & D Wellbery (eds.) *Reconstructing individualism: Autonomy, individuality, and the Self in Western thought*, Stanford University Press, Stanford.

Hacking, I 1990, *The taming of chance*, Cambridge University Press, Cambridge.

Hacking, I 1991, 'How should we do a history of statistics?', in G Burchell, C Gordon & P Miller (eds.) *The Foucault Effect: Studies in Governmental Rationality*, Harvester Wheatsheaf, London, pp. 181-196.

Hacking, I 1995, 'The looping effects of human kinds', in D Sperber, D Premack & A Premack, *Causal cognition: A multi-disciplinary debate*, Oxford University Press, New York, pp. 351-383.

Hagan, J, Castle, R & Clothier, C 1998, 'Fixing wages for Aborigines in the Queensland cattle industry 1901-1965', *Journal of industrial relations*, vol. 40, no, 3, pp. 409-421.

Hall, S & Jefferson, T 1975 (eds), *Resistance through rituals: Youth subcultures in post-war Britain*, Hutchinson, London.

Hall, W & Lucke, J 2010, 'Legally coerced treatment for drug using offenders: Ethical and policy issues', *Contemporary issues in criminal justice*, no. 144, New South Wales Bureau of Crime Statistics and Research.

Hamlin, C 1998, 'Revolutions in public health: 1848, and 1998?', *British Medical Journal*, vol. 317, 29 August 1998, pp. 587-591.

Hammersley, M 1992, *What's wrong with ethnography?*, Routledge, London.

Hammersley, M & Atkinson, P 2007, *Ethnography: Principles in practice*, 3rd, edn., Routledge, London.

Hammersley, R & Reid, M 2002, 'Why the pervasive addiction myth is still believed', *Addiction Research and Theory*, vol. 10, pp. 7-30.

Hammersley, R, Khan, F & Ditton, J 2002, 'Ecstasy and the Rise of the Chemical Generation', *International Journal of Drug Policy*, vol. 13, no. 5, pp. 437-438.

Harding, G 1986, 'Constructing addiction as moral failing', *Sociology of health and illness*, vol. 8 (March), pp. 75-85.

Hay, C 2004, 'The normalizing role of rationalist assumptions in the institutional embedding of neoliberalism', *Economy and society*, vol. 33, no. 4, pp. 55-527.

Heyman, G 2009, *Addiction: A Disorder of Choice*, Harvard University Press, Cambridge.

Hickman, T 2004, '"Mania Americana". Narcotic addiction and modernity in the United States, 1870-1920', *The Journal of American History*, vol. 90, no. 4, pp. 1269-1294.

Hindess, B 1993, 'Liberalism, socialism and democracy: Variations on a governmental theme', *Economy and Society*, vol. 22, no. 3, pp. 300-313.

Hindess, B. (1996). Discourses of power: From Hobbes to Foucault. Blackwell: Oxford.

Hoffman, M. (2001-2002).' The rehabilitative ideal and the drug court reality', *Federal sentencing reporting*, vol. 14, no. 3-4, pp. 172-178.

Hogg, R. 2007, 'Punishment and the Courts in Rural Communities', in Barclay, E, Donnermeyer, J, Hogg, R. & Scott, J (eds.), *Crime in Rural Australia*, Federation Press, Sydney, pp. 167-81.

Hogg, R & Brown, D 1998, *Rethinking law and order*, Pluto Press, Annandale.

Hogg, R & Carrington, K 2001, 'Governing rural Australia: Land, space and race', in G Wickham & G. Pavlich (eds.), *Rethinking law, society and governance: Foucault's bequest*, Hart Publishing, Oxford, pp. 43-60.

Hogg, R & Carrington, K 2003, 'Violence, spatiality and other rurals', *The Australian and New Zealand Journal of Criminology*, vol. 36, no. 3, pp. 293-319.

Hogg, R & Carrington, K 2006, *Policing the rural crisis*, Federation Press, Sydney.

Hough, M 2001, 'Balancing public health and criminal justice interventions', *International journal of drug policy*, vol. 12, pp. 429-433.

Howard, J & Borges, P 1970, 'Needle-sharing in the Haight: Some social and psychological functions', *Journal of health and social behaviour*, vol. 11, no. 3, pp. 220-230.

Hughes, C & Ritter, A 2008, *A summary of diversion programs for drug and drug related offenders in Australia*, Drug Policy Modelling Program, Monograph 16, National Drug and Alcohol Research Centre, Sydney.

Hunt, A & Wickham, G 1994, *Foucault and law: Towards a sociology of law as governance*, Pluto Press, London.

International Narcotics Control Board 2010, *Report of the International Narcotics Control Board for 2009*, United Nations, New York. http://www.un.org.au/files/files/INCB%202009%20Report.pdf

International Narcotics Control Board 2012, *Mandate and functions*, INCB, viewed October 30, 2012. http://www.incb.org/incb/en/about/mandate-functions.html

Jaffe, J 1999, 'Conversation with Jeremy H. Jaffe', Journal Interview – 45, *Addictions*, vol, 94, no. 1, pp. 13-30.

Jellinek, E 1960, *The Disease Concept of Alcoholism*, Rutgers Centre of Alcohol Studies, New Jersey.

Johns, R 2004, *Drug Offences: An Update on Crime Trends, Diversionary Programs and Drug Prisons*, Briefing Paper no 7/04, New South Wales Parliamentary Library, Sydney.

Jones, R 2011, 'Eugenics in Australia: The secret of Melbourne's elite', *The Conversation*, 21 September, 2011, viewed February 9, 2013. http://theconversation.com/eugenics-in-australia-the-secret-of-melbournes-elite-3350

Keane, H 2001, 'Public and private practices: Addiction autobiography and its contradictions', *Contemporary drug problems*, vol. 28, pp. 567-595.

Keane, H 2002, *What's wrong with addiction?* Melbourne University Press, Melbourne.

Kelly, P 2006, 'The entrepreneurial self and 'Youth at risk': Exploring the horizons of identity in the twenty-first century', *Journal of youth studies*, vol. 9, no. 1, pp. 17-32.

Kelly, P 2013, *The self as enterprise: Foucault and the spirit of 21st century capitalism*, Gower Publishing, Surrey. http://reader.eblib.com.au.ezp01.library.qut.edu.au

Kendall, G 2003*a*, *From Liberalism to Neoliberalism*, Paper presented to the Social Change in the 21st Century Conference, Centre for Social Change Research, Queensland University of Technology, 21 November 2003, Queensland University of Technology, Brisbane.

Kendall, G 2003*b*, *What is Neoliberalism?* The Australian Sociological Association 2003 Conference, University of New England, 4-6 December, 2003, University of New England, Armidale.

Kendall, G 2011, 'Foucaultian approaches to the self', in A Elliott (ed.), *The Routledge Handbook of identity studies*, Routledge, London.

Kendall, G & Wickham, G 1992, 'Health and the social body', in S Scott, G Williams, S Platt & H Thomas (eds.), *Private risks and public dangers*, Explorations in Sociology, no. 43, Avebury, Aldershot.

Kendall, G & Wickham, G 1999, *Using Foucault's methods*, Sage, London.

Kendall, G & Wickham, G 2004, 'The Foucaultian framework', in C Seale, G Gobo, J Gubrium & D Silverman (eds.), *Qualitative research practice*, Sage, London.

Kendall, G, Woodward, I & Skrbis, Z 2009, *The sociology of cosmopolitanism: Globalization, identity, culture and government*, Palgrave Macmillan, Basingstoke.

Kinsman, G 1996, ''Responsibility as a strategy of governance: Regulating people living with AIDS and lesbians and gay men in Ontario', *Economy and Society*, vol. 25, no. 3, pp. 393-409.

Kohn, M 1992, *Dope girls: The birth of the British underground*, Granta, London.

Kvale, S 1995, 'The social construction of validity', *Qualitative inquiry*, vol. 1, pp. 19-40.

Lambert, A, Benedict, S, Gregory, M, McGoldrick, T, Strauss, I., Wallace, G & Williams, L 1930, 'Report of the Mayor's Committee on Drug Addiction to the Hon. Richard C Patterson, Jr., Commissioner of Correction, New York City', *American journal of psychiatry*, vol. 87, pp. 433-538.

Lart, R 1998, 'Medical power and knowledge: The treatment and control of drugs and drug users', in R Coomber (ed.), *The control of drugs and drug users: Reason or reaction*? Harwood academic publishers, Amsterdam.

Latour, B 1986, 'The powers of association', in J Law (ed.), *Power, action and belief*, Routledge and Kegan Paul, London.

Latour, B 2000, 'When things strike back: A possible contribution of 'social studies' to the social sciences', *British journal of sociology*, vol. 51, no. 1, pp. 107-123.

Latour, B 2004, 'Why has critique run out of steam? From matters of fact to matters of concern', *Critical inquiry*, vol. 30, no. 2, pp. 225-248.

Latour, B 2005, Reassembling the social: An introduction to actor-network theory, Oxford University Press, Oxford.

Latour, B & Woolgar, S 1986, *Laboratory life: The construction of scientific facts*, Princeton University Press, New Jersey.

Law, J 2004, *After method: Mess in social science research*, Routledge, London.

Legislative Council of New South Wales 2007, *Hansard*, Leglislative Council of New South Wales, 8 November 2007, New South Wales Parliament, viewed December 19, 2009. http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LC20071108038?open&refNavID=HA8_1

Lemke, T 2001, 'The birth of biopolitics – Michel Foucault's lecture at the College de France on Neo-Liberal Governmentality', *Economy and Society*, vol. 30, no. 2, pp. 190-207.

Lemke, T 2010, 'Foucault's hypothesis: From the critique of the juridico-discursive concept of power to an analytics of government', *Parrhesia*, vol. 9, pp. 31-43 [online open-access journal, viewed March 21, 2012. www.parrhesiajournal.org]

Lenton, S & Single, E 1998, 'The definition of harm reduction', *Drug and alcohol review*, vol. 17, pp. 213-220.

Leshner, A 1997, 'Addiction is a Brain Disease and it Matters', *Science* New Series, vol. 278, no. 5335, pp. 45-47.

Levine, H 1974, '"Needle freaks": Compulsive self-injection by drug users', *American journal of psychiatry*, vol. 131, no. 3, pp. 297-300.

Levine, H 1978, 'The discovery of addiction: Changing conceptions of habitual drunkenness in America', *Journal of studies on alcohol*, vol. 15, pp. 493-506.

Levine, H & Reinarman, C 1991, 'From prohibition to regulation: Lessons from alcohol policy for drug policy', *The Milbank Quarterly*. Confronting Drug Policy: Part 1 (1991), vol. 69, no. 3, pp. 461-494.

Lincoln, Y & Guba, E 1985, *Naturalistic inquiry*, Sage, Beverly Hills.

Lintner, B 2002, *Blood brothers: Crime, business and politics in Asia*, Silkworm Books, Chiang Mai.

Lippert, R & Stenson, K 2010, 'Advancing governmentality studies: Lessons from social constructionism', *Theoretical criminology*, vol. 14, no. 4, pp. 473-494.

Lupton, D 1995, *The imperative of health: Public health and the regulated body*, Sage Publications, London.

Lupton, D 1997, 'Foucault and the medicalization critique', in A Peterson & R Bunton (eds.), *Foucault, health and medicine*, Routledge, London, pp. 94-112.

MacCoun, R & Reuter, P 2001, *Drug war heresies: Learning from other vices, times and places*, Cambridge University Press, Cambridge.

MacLean, S 2005, 'It might be scummy-arsed but it's a sick buzz: Chroming and pleasure', *Contemporary drug problems*, vol. 32, no. 2, pp. 295-318.

Maher, L 2001, *Sexed work: Gender, race and resistance in a Brooklyn drug market*, Oxford University Press, Oxford.

Maher, L & Dixon, D 2001, 'The cost of crackdowns: Policing Cabramatta's heroin market', *Current issues in criminal justice*, vol. 13, no. 1, pp. 5-22.

Maher, L, Li, J, Jalaludin, B, Wand, H, Jayasuriya, R, Dixon, D & Kaldor, J 2007, 'Impact of a reduction in heroin availability on patterns of drug use, risk behaviour and incidence of hepatitis C virus infection in injecting drug users in New South Wales, Australia', *Drug and Alcohol Dependence*, vol. 89, pp. 244-50.

Makkai, T & Payne, J 2003, Key Findings from the Drug Use Careers of Offenders (DUCO) Study, *Trends and Issues in Crime and Criminal Justice*, no. 267, pp. 1-8.

Malpas, J & Wickham, G 1995, 'Governance and failure: On the limits of sociology', *Journal of sociology*, vol. 31, no. 3, pp. 37-50.

Manderson, D 1987, *Proscription and Prescription: Commonwealth Government Opiate Policy 1905-1937*, Australian Government Publishing Service, Canberra.

Manderson, D 1993, *From Mr Sin to Mr Big: A history of Australian drug laws*, Oxford University Press, Melbourne.

Manderson, D 1999, 'Symbolism and racism in drug history and history', *Drug and alcohol review*, vol. 18, pp. 179-186.

Manski, C 2003, 'Credible research practices to inform drug law enforcement', *Criminology and public policy*, vol. 2, no. 3, pp. 543-556.

Marlowe, D, Kirby, K, Bonieskie, L, Glass, D, Dodds, L, Husband, S, Platt, J & Festiger, D 1996, 'Assessment of coercive and noncoercive pressures to enter drug abuse treatment', *Drug and alcohol dependence*, vol. 42, pp. 77-84.

Martin, A & Stenner, P 2004, 'Talking about drug use: What are we (and our participants) doing in qualitative research?', *International journal of drug policy*, vol. 15, pp. 395-405.

Mauss, M 1973, 'Techniques of the body', *Economy and society*, vol. 2, no. 1, pp. 70-88.

May, T 2002, *Social research: Issues, methods and process*, 3rd edn, Open University Press, Buckingham.

Mazerolle, L, Soole, D & Rombouts, S 2007, 'Drug law enforcement: A review of the evaluation of literature', *Police Quarterly*, vol. 10, no. 2, pp. 115-153.

McCallum, D 1993, 'Problem children and familial relations', in D Meredyth & D Tyler (eds.), *Child and citizen: Genealogies of schooling and subjectivity*, Faculty of Humanities, Griffith University, Brisbane.

McCallum, D 1998, 'Dangerous individuals: Government and the concept of personality', in M Dean & B Hindess (eds.), *Governing Australia: Studies in contemporary rationalities of government*, Cambridge University Press, Cambridge.

McCallum, D 2004, 'Law and norm: Justice administration and the human sciences in early juvenile justice in Victoria', *Newcastle law review*, vol. 7, no. 2, pp. 62-71.

McCallum, D 2008, 'The contingent object of psychiatry', *Philosophy, psychiatry, and psychology*, vol. 15, no. 1, pp. 69-71.

McCallum, D & Laurence, J 2007, 'Has welfarist criminology failed? Juvenile justice and the human sciences in Victoria', *Australian social work*, vol. 60, no. 4, pp. 410-420.

McCoy, A 2000, 'Coercion and its unintended consequences: A study of heroin trafficking in Southeast and South Western Asia', *Crime, law and social change*, vol. 33, no. 3, pp.191-224.

McGee, T, Wickes, R, Bor, W & Najman, J 2009, *Antisocial behaviour across neighbourhoods: Individuals and families in context*, Report to the Criminology Research Council Grant: CRC 19 07/08, December 2009, Australian Institute of Criminology, Canberra.

Measham, F, Aldridge, J, & Parker, H 1998, 'The teenage transition: From recreational drug use to the dance culture', *Journal of drug use*, vol. 28, no. 1, pp. 9-22.

Measham, F & Shiner, M 2009, 'The legacy of 'normalisation': The role of classical and contemporary criminological theory in understanding young people's drug use', *International Journal of Drug Policy*, vol. 20, pp. 502-508.

Metherell, M 2012, 'Gillard and Carr divided over decriminalisation of drugs', *Sydney Morning Herald*, April 3, 2012, viewed November 7, 2012. http://www.smh.com.au/opinion/political-news/gillard-and-carr-divided-over-decriminalisation-of-drugs-20120403-1w9iz.html

Miller, P 2001, 'A review of the harm minimization ideology in Australia', *Critical public health*, vol. 11, no. 2, pp. 167-178.

Miller, P & Rose, N 1997, 'Mobilizing the consumer: Assembling the subject of consumption', *Theory, culture and society*, vol. 14, no. 1, pp. 1-36.

Ministerial Council on Drug Strategy 2004, *The National Drug Strategy: Australia's integrated framework 2004-2009*, Ministerial Council on Drug Strategy, Sydney.

Mischler, E 1990, 'Validation in inquiry-guided research: The role of exemplars in narrative studies', *Harvard educational review*, vol. 60, no. 4, pp. 415-442.

Mold, A 2004, 'The 'British system' of heroin addiction treatment and the opening of drug dependence units, 1965-1970', *Social history of medicine*, vol. 17, no. 3, pp. 501-517.

Mold, A & Berridge, V 2010, *Voluntary action and illegal drugs: Health and society in Britain since the 1960s*, Palgrave Macmillan, London.

Moore, D 1990, 'Anthropological reflections on youth drug use research in Australia: What we don't know and how we should find out', *Drug and alcohol review*, vol. 9, pp. 333-342.

Moore, D 1992, 'Deconstructing "dependence": an Ethnographic Critique of an Influential Concept', *Contemporary Drug Problems*, vol. 19, no. 3, pp. 459-490.

Moore, D 2002, 'Opening up the cul-de-sac of youth drug studies: A contribution to the construction of some alternative truths', *Contemporary drug problems*, vol. 29, pp. 13-64).

Moore, D 2008, 'Erasing pleasure from public discourse on illicit drugs: On the creation and reproduction of an absence', *International journal of drug policy*, vol. 19, pp. 353-358.

Moore, T 2005, *What is Australia's "drug budget"? The policy mix of illicit drug related government spending in Australia* (DPMP Monograph Series). Monograph no. 1, Turning Point Alcohol and Drug Centre, Melbourne.

Motbey, C 2013, 'Party's over: Mephadrone causes memory impairment', *The Conversation*, viewed March 30, 2013. http://theconversation.edu.au/partys-over-mephedrone-causes-memory-impairment-9672

Muncie, J 2005, 'The globalization of crime control – the case of youth and juvenile justice: Neoliberalism, policy convergence and international conventions', *Theoretical criminology*, vol. 9, no. 1, pp. 35-64.

Musto, D 1999, *The American disease: Origins of narcotics control*, Oxford University Press, Oxford.

Narcotics Anonymous 2008, *Narcotics Anonymous*, Narcotics Anonymous World Services, California.

New South Wales Parliament Legislative Council Select Committee on the Increase in Prisoner Population 2001, *Final Report*, Parliamentary Paper, no. 924, Legislative Council Select Committee on the Increase in Prisoner Population, New South Wales Parliament, Sydney.

Nicholas, R, Lee, N, & Roche, A 2011, *Pharmaceutical drug misuse in Australia: Complex problems, balanced responses*, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.

Ning, A 2005, 'Games of truth: Rethinking conformity and resistance in narratives of heroin recovery', *Medical anthropology*, vol. 24, no. 4, pp. 349-382.

O'Brien, C & McLellan, A 1996, 'Myths about the Treatment of Addiction, *Lancet*, vol. 347, pp. 237-240.

O'Farrell, C 2005, *Michel Foucault*. Sage, London.

Office of National Drug Control Policy 2011, *National drug control strategy: FY 2012 Budget Summary*, Office of the President: Washington DC, viewed February 23, 2012. http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/fy12highlight_exec_sum.pdf

O'Malley, P 1996, 'Risk and responsibility', in B Andrew, T Osborne & N Rose (eds.), Foucault and political reason: Liberalism, neo-liberalism and rationalities of government, UCL Press, London.

O'Malley, P 1999, 'Consuming risks: Harm minimization and the government of 'drug-users'', in R Smandych (ed.), *Governable places: Readings on governmentality and crime control*, Ashgate, Aldershot.

O'Malley, P 2004, *Risk, uncertainty and government*, The GlassHouse Press, Sydney.

O'Malley, P & Valverde, M 2004, 'Pleasure, freedom and drugs: The uses of 'pleasure' in liberal governance on drug and alcohol consumption', *Sociology*, vol. 38, no. 1, pp. 25-42.

Osborne, T 1996, 'Security and vitality: Drains, liberalism and power in the nineteenth century', in A Barry, T Osborne & N Rose (eds.), *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, UCL Press, London.

Parker, H. and Newcombe, R. (1987). 'Heroin use and acquisitive crime in an English community', *British journal of sociology*, vol. 38, pp. 331-350.

Parker, H, Aldridge, J & Measham, F 1998, *Illegal Leisure: The Normalization of Adolescent Recreational Drug Use*. Routledge, London.

Parker, H, Williams, L & Aldridge, J 2002, 'The normalization of sensible recreational drug use: More evidence from the North West England longitudinal study', *Sociology*, vol. 36, no. 4, pp. 941–964.

Parssinen, T & Kerner, K 1980, 'Development of the disease model of drug addiction in Britain, 1870-1926', *Medical history*, vol. 24, pp. 275-296.

Pasquino, P 1991, 'The genealogy of capital', in G Burchell, C Gordon & P Miller, *The Foucault Effect*, Harvester Wheatsheaf, London, pp. 105-118.

Pates, R, McBride, A, Ball, N & Arnold, K 2001, 'Towards an holistic understanding of injecting drug use: An overview of needle fixation', *Addiction Research and theory*, vol. 9, no. 1, pp. 3-17.

Patton, M 2002, *Qualitative research and evaluation methods*, 3rd edn, Sage, California.

Pearson, G 1996, 'Drugs and Deprivation', *The Journal of the Royal Society for the Promotion of Health*, vol. 116, pp. 113-116.

Pedersen, E 2002, 'Practices of government in methadone maintenance', *Outlines: Critical practice studies*, vol. 4, no. 2, pp. 61-69.

Pennay, A & Moore, D 2010, 'Exploring the micro-politics of normalization: Narratives of pleasure, self-control and desire in a sample of young Australian 'party drug' users', *Addiction, research and theory*, vol. 18, no. 5, pp. 557-571.

Pereira, M & Scott, J 2012, 'Inequalities of crime', in M Marmo, W de Lint & D Palmer, *Crime and justice: A guide to criminology*, 4th edn, Lawbook Company, Sydney.

Petersen, A & Lupton, D 1996, *The new public health: Health and self in the age of risk*, Allen and Unwin, St Leonards.

Plummer, D & Irwin, L 2006, 'Grassroots activities, national initiatives and HIV prevention: Clues to explain Australia's dramatic early success in controlling the HIV epidemic', *International Journal of STD and AIDS*, vol. 17, pp. 787–793.

Pritchard, E, Mugavin, J & Swan, A 2007, *Compulsory treatment in Australia: A discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*, A report for the Australian National Council on Drugs, Australian National Council on Drugs, Canberra, viewed October 13, 2009. http://www.nobars.org.au/downloads/rp14_compulsory_treatment.pdf

Pugh, J 2008, 'Hepatitis C and the Australian news media: A case of 'bad blood'', *Continuum: Journal of media and cultural studies*, vol. 22, no. 3, pp. 385-394.

Queensland Corrective Services 2006, *Drug strategy 2006: Tackling drug abuse and addiction, changing lives in Queensland prisons*, Queensland Corrective Services, Brisbane, viewed August 14, 2011. http://www.correctiveservices.qld.gov.au/Resources/Policies/Documents/DrugStrategy.pdf

Queensland Police 2012, *Police Diversion Program for a minor drugs offence (cannabis)*, Queensland Police, Brisbane, viewed December 2, 2012. http://www.police.qld.gov.au/Resources/Internet/programs/drugs/documents/pdp_general.pdf

Rabinow, P (ed.) 1984, *The Foucault reader*, Penguin Books, London.

Rabinow, P 1997, 'Introduction: The history of systems of thought', in P Rabinow (ed.), *Ethics, subjectivity and truth: The essential works of Michel Foucault 1954-1984*, Volume one, The New Press, New York, pp. xi-xlv.

Rabinow, P & Rose, N 2003, *The essential Foucault: Selections from essential works of Foucault 1954 – 1984*, The New Press, New York.

Ramsland, J 1986, *Children of the backlanes: Destitute and neglected children in colonial New South Wales*, New South Wales University Press, Sydney.

Reinarman, C 2005, 'Addiction as accomplishment: The discursive construction of disease', *Addiction, research and theory*, vol. 13, no. 4, pp. 307-320.

Reith, G 2004, 'Consumption and its discontents: Addiction, identity and the problems of freedom', *British journal of sociology*, vol. 55, no. 2, pp. 283-300.

Ren, H 2005, 'Subculture as a neo-liberal conduct of life in leisure and consumption', *Rhizomes*, vol. 10, Spring, pp. 1-22.

Reynolds, C 1995, 'Can we make sense of drug law in Australia? A case study of the South Australian legislation', *Flinders Journal of Law Reform*, vol. 1, pp. 73-84.

Reynolds, H 1989, 'The frontier: Peaceful settlement or brutal conquest? *In Dispossession: Black Australians and white invaders*, Allen and Unwin, Sydney, pp. 24-65.

Rhodes, T & Moore, D 2001, 'On the qualitative in drug research: Part one', *Addiction, research and theory*, vol. 9, no. 4, pp. 279-297.

Ritter, A & Cameron, J 2005, *A systematic review of harm reduction*, Drug Policy Modelling Project, Monograph 06, Turning Point Alcohol and Drug Centre: Fitzroy, viewed September 1, 2012. http://ndarc.med.unsw.edu.au/sites/ndarc.cms.med.unsw.edu.au/files/ndarc/resources/06%20A%20systematic%20review%20of%20harm%20reduction.pdf

Roberts, L & Indermaur, D 2006, 'Timely intervention or trapping minnows? The potential for a range of net-widening effects in Australian drug diversion initiatives', *Psychiatry, psychology and law*, vol. 13, no. 2, pp. 220-231.

Robertson, J, Bucknall, A, Welsby, P, Roberts, J, Inglis, J, Peutherer, J & Brettle, R 1986, 'Epidemic of AIDS related virus (HTLV-III/LAV) infection among intravenous drug abusers', *British medical journal*, vol. 292, pp. 527-529.

Rodwell, G 2000, ''Persons of lax morality': Temperance, eugenics and education in Australia, 1900-1930', *Journal of Australian studies*, vol. 24, no. 64, pp. 62-74.

Roe, G 2006, 'Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction', *Critical public health*, vol. 15, no. 3, pp. 243-250.

Rolles, S, Kushlick, D & Jay, M 2004, *After the war on drugs: Options for control*, Transform Drug Policy Foundation: Bristol, viewed March 20, 2009. http://www.tdpf.org.uk/Transform_After_the_War_on_Drugs.pdf

Rose, N 1985, *The psychological complex: Psychology, politics and society in England, 1869-1939*, Routledge and Kegan Paul, London.

Rose, N 1990, 'Of madness itself: *Historie de la folie* and the object of psychiatric history'. *History of the human sciences*, vol. 3, no. 3, pp. 373-380.

Rose, N 1991, 'Governing by numbers: Figuring out democracy', *Accounting Organizations and Society*, vol. 16, no. 7, pp. 673-692.

Rose, N 1993, 'Government, authority and expertise in advanced liberalism', *Economy and Society*, vol. 22, no. 3, pp. 283-299.

Rose, N 1996a, 'The death of the social? Re-figuring the territory of government', *Economy and Society*, vol. 25, no. 3, pp. 327-356.

Rose, N 1996*b*, 'Governing advanced liberal democracies', in A Barry, T Osborne & N Rose (eds.), *Foucault and political reason: Liberalism, neo-liberalism and rationalities of government*, UCL Press, London.

Rose, N 1996*c*, *Inventing Our Selves: Psychology, Power and Personhood*, Cambridge University Press, Cambridge.

Rose, N 1997, 'Power in therapy: Techne and ethos'. Paper presented at the Universities Psychotherapy Association annual Conference, *Power and influence in psychotherapy*, 14-15 November, 1997, University of London, viewed 21 March, 2012. http://www.academyanalyticarts.org/rose2.htm

Rose, N 1999*a*, *Governing the soul: The Shaping of the private self*, 2nd edn, Free Association Books, New York.

Rose, N 1999*b*, *Powers of freedom: Reframing political thought*. Cambridge University Press, Cambridge.

Rose, N 2000, 'Government and control', *British Journal of Criminology*, vol. 40, pp. 321-339.

Rose, N 2001*a*, 'The neurochemical Self and its anomalies', in R Ericson (ed.), *Risk and Morality*, University of Toronto Press, Toronto, pp. 407-437.

Rose, N 2001*b*, 'The politics of life itself', *Theory, culture, society*, vol. 18, no. 6, pp. 1-30.

Rose, N 2006, *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century*, Princeton University Press, New Jersey.

Rose, N 2009, 'Normality and pathology in a biomedical age', *Sociological review*, vol. 57, pp. 68-83.

Rose, N & Miller, P 1992, 'Political Power beyond the State: Problematics of Government', *The British Journal of Criminology*, vol. 43, no. 2, pp. 173-205.

Rose, N & Novas, C 2005, 'Biological citizenship', in A Ong & S Collier (eds.), *Global assemblages: Technology, politics and ethics and anthropological problems*, pp. 439-464.

Rose, N & Valverde, M 1998, 'Governed by law?', *Social legal studies*, vol. 7, no. 4, pp. 441-551.

Royal commission into the Non-Medical Use of Drugs, South Australia 1978, *The Social Control of Drug Use: a discussion paper*, Royal Commission into the Non-Medical Use of Drugs (South Australian Government), Adelaide.

Sacco, L & Finklea, K 2011, *Synthetic drugs: Overview and issues for Congress*, CRS Report for Congress, Congressional Research Service R42066, October 28 2011, viewed November 28, 2012. http://www.fas.org/sgp/crs/misc/R42066.pdf

Sanders, B 2006, 'Young people, clubs and drugs', in B. Sanders (ed.), *Drugs, clubs and young people: Sociological and public health perspectives*, Ashgate, Aldershot.

Schur, E 1963, 'Drug addiction under British policy', in H Becker (ed.), *Perspectives on deviance: The other side*, The Free Press, New York.

Scott, J 2003, 'Prostitution and public health in New South Wales', *Culture, health and sexuality*, vol. 5, no. 3, pp. 277-293.

Scott, J 2005, *How modern governments made prostitution a social problem: Creating a responsible prostitute population*, Edwin Mellen Press, New York.

Scott, J 2011-2012, 'Governing prostitution: Differentiating the bad from the bad', *Current issues in criminal justice*, vol. 23, no. 1, pp. 53-72.

Scraton, P & McCulloch, J 2009, *The violence of incarceration*, Routledge, New York.

Seddon, T 2006, 'Drugs, crime and social exclusion: Social context and social theory in British drugs-crime research', *British journal of criminology*, vol. 46, pp. 680-703.

Seddon, T 2007*a*, 'Coerced drug treatment in the criminal justice system: Conceptual, ethical and criminological issues', *Criminology and criminal justice*, vol. 7, no. 3, pp. 269-286.

Seddon, T 2007*b*, 'The regulation of heroin: Drug policy and social change in early twentieth-century Britain', *International journal of the sociology of the law*, vol. 35, pp. 143-156.

Seddon, T 2008, 'Women, harm reduction and history: Gender perspectives on the emergence of the 'British system' of drug control', *International journal of drug policy*, vol. 19, pp. 99-105.

Seddon, T 2010, *A history of Drugs: Drugs and freedom in the liberal age.* Routledge, Abingdon, viewed November 2, 2012. http://www.qut.eblib.com.au.ezp01.library.qut.edu.au/patron

Seddon, T 2011*a*, 'What is a problem drug user', *Addiction, research and theory*, vol. 19, no. 4, pp. 334-343.

Seddon, T 2011*b*, 'Court-ordered treatment, neoliberalism and *Homo economicus*', in S Fraser & D Moore (eds.), *The drug effect: Health, crime and society*, Cambridge University Press, Cambridge, pp. 155-170.

Seddon, T., Ralphs, R. and Williams, L. (2008). 'Risk, security, and the 'criminalization' of British drug policy', *British Journal of Criminology*, vol. 48, pp. 818-834.

Sedgwick, E 1992, 'Epidemics of the will', in J Crary & S Kwinter, *Incorporations*, Urzone Inc, New York.

Shaw, C & McKay, M 1942, *Juvenile delinquency and urban areas*, University of Chicago Press, Chicago.

Shiner, M. & Newburn, T 1997, 'Definitely, maybe not: The normalisation of recreational drug use amongst young people', *Sociology*, vol. 31, no. 3, pp. 511–529.

Silver, D 2001, *Interpreting qualitative data: Methods for analysing talk, text and interaction*, 2nd edn, Sage, London.

Silverman, J 2010, 'Addicted to distortion: The media and UK drugs policy', *Safer communities*, vol. 9, no. 4, pp. 26-31.

Simmonds, L & Coomber, R 2009, 'Injecting drug users: A stigmatised and stigmatising population', *International journal of drug policy*, vol. 20, pp. 121-130.

Simpson, M 2003, 'The relationship between drug use and crime: a puzzle inside an enigma', *International Journal of Drug Policy*, vol. 14, pp. 307–319.

Single, E 1995, 'Defining harm reduction', *Drug and alcohol review*, vol. 15, pp. 287-290.

Snyder, S & Pasternak, G 2003, 'Historical review: Opioid receptors', *Trends in pharmacological sciences*, vol. 24, no. 4, pp. 198-205.

Spear, H 1969, 'The growth of heroin addiction in the United Kingdom', *British journal of addiction*, vol. 64, pp. 245-255.

Stafford, J, Burns, L 2011, *Findings from the illicit drug reporting system (IDRS)*, Australian Drug Trends Series, No. 55, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, viewed January 4, 2012. http://ndarc.med.unsw.edu.au/sites/ndarc.cms.med.unsw.edu.au/files/ndarc/resources/IDRSDTS2010.pdf

Stewart, T 1987, *The Heroin Users*, HarperCollins, London.

Stimson, G & Choopanya, K 1998, 'Global perspectives on drug injecting'. In A Ball, D Des Jarlais & G Stimson (eds.), *Drug injecting and HIV infection*, UCL Press, London.

Sweeney, J & Payne, J 2012, *Drug use monitoring in Australia: 2009-2010 report on drug use among police detainees*, AIC Reports, Monitoring Reports 17, Australian Institute of Criminology, Canberra, viewed October 6, 2012. http://aic.gov.au/documents/5/E/6/%7B5E6E097D-65A5-4E20-9733-E06D4C27328F%7Dmr17.pdf

Szasz, T 1971, 'The ethics of addiction', *American journal of psychiatry*, vol. 128, no. 5, pp. 541-546.

Tait, R.,Ngo, H & Hulse, G 2008, 'Mortality in heroin users 3 years after naltrexone implant or methadone maintenance treatment', *Journal of substance abuse treatment*, vol. 35, pp. 116-124.

Tamboukou, M & Ball, S 2003, 'Genealogy and ethnography: Fruitful encounters or dangerous liaisons?' in M Tamboukou & S Ball (eds.), *Dangerous encounters: Genealogy and ethnography*, Peter Lang, New York, pp. 1-36.

The Australasian Professional Society on Alcohol and other Drugs 2011, *Ignorance about potentially harmful and addictive new psychoactive drugs raises public health concerns*, Media Release, The Australasian Professional Society on Alcohol and other Drugs, viewed July 29, 2012. http://ndarc.med.unsw.edu.au/sites/ndarc.cms.med.unsw.edu.au/files/newsevents/events/APSAD%20Ignorance%20about%20new%20synthetic%20drugs%20raises%20concerns%20151111.pdf

Tittle, C & Meier, R 1990, 'Specifying the SES/Delinquency relationship', *Criminology*, vol. 28, pp. 271-301.

Treichler, P 1999, *How to have theory in an epidemic: Cultural chronicles of AIDS*, Duke University Press, Durham.

United Nations Office on Drugs and Crime 1998a, *Special Session of the General Assembly devoted to countering the world drug problem together 8-10 June 1998*, UNODC, viewed June 2, 2012. http://www.unodc.org/pdf/report_1999-01-01_1.pdf

United Nations Office on Drugs and Crime 1998b, *United Nations General Assembly Special Session on the world drug problem, New York, 8-10 June, 1998*, Fact Sheet 4, viewed June 6, 2012. http://www.un.org/ga/20special/presskit/themes/demand-4.htm

United Nations Office on Drugs and Crime 2009, *A century of international drug control*, UNODC, viewed June 15, 2012. http://www.unodc.org/documents/data-and-analysis/Studies/100_Years_of_Drug_Control.pdf

United Nations Office on Drugs and Crime 2010, *From coercion to cohesion: Treating drug dependence through healthcare, not punishment*, Discussion paper, United Nations Office on Drugs and Crime: Vienna, viewed September 5, 2012. http://www.drugtext.org/pdf/International-national-drug-policy/from-coercion-to-cohesion-treating-drug-dependence-through-healthcare-not-punishment.pdf

United Nations Office on Drugs and Crime 2012a, *The plenipotentiary conference for the adoption of a Single Convention on Narcotic Drugs*, UNODC, viewed November 30, 2012. http://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1962-01-01_1_page007.html

United Nations Office on Drugs and Crime 2012b, *World Drug Report*, UNODC, viewed November 30, 2012. http://www.unodc.org/documents/data-and analysis/WDR2012/WDR_2012_web_small.pdf

Valentine, K 2007, 'Methadone maintenance treatment and making up people', *Sociology*, vol. 41, no. 3, pp. 497-514.

Valentine, K & Fraser, S 2008, 'Trauma, damage and pleasure: Rethinking problematic drug use', *International journal of drug policy*, vol. 19, pp. 410-416.

Valverde, M 1998, *Diseases of the Will: Alcohol and the dilemmas of freedom*, Cambridge University Press, Cambridge.

Van Beek, I 2003, 'The Sydney medically supervised injecting centre: A clinical model', *Journal of drug issues*, vol. 33, no. 3, pp. 625-638.

Vrecko, S 2010a, 'Birth of a brain disease: Science, the state and addiction neuropolitics', *History of the human sciences*, vol. 23, no. 4, pp. 52-67.

Vrecko, S 2010b, ''Civilizing technologies' and the control of deviance', *BioSocieties*, vol. 5, no. 1, pp. 36-51.

Wallace, V 1962, 'The Eugenics Society of Victoria, 1936-1961)', *The eugenics review*, vol. 53, no. 4, pp. 215-218.

Walmsley, I 2012, 'Governing the injecting drug user: Beyond needle fixation', *History of the human sciences*, vol. 25, no. 4, pp. 90-107.

Wodak, A & Moore, T 2002, *Modernising Australia's drug policy*, University of New South Wales Press, Sydney.

World Health Organization 1964, *WHO Expert Committee on addiction-producing drugs*, World Health Organization Technical Report Series No. 273, World Health Organization: Geneva, viewed September 13, 2012. http://whqlibdoc.who.int/trs/WHO_TRS_273.pdf

World Health Organization 1969, *WHO Expert Committee on Drug Dependence Sixteenth Report*, World Health Organization Technical Report Series No. 407, World Health Organization, Geneva, viewed September 24, 2012. http://whqlibdoc.who.int/trs/WHO_TRS_407.pdf

Young, J 1971, *The Drug Takers: The Social Meaning of Drug Use*, Paladin, London.

Young, J 1999, *The Exclusive Society: Social Exclusion, Crime and Difference in Late Modernity*, Sage Publications, London.

Zinberg, N 1984, *Drug, Set, and Setting: The Basis of Controlled Intoxicant Use*, Yale University Press, New Haven.

Appendix A: Ethics approval and issues of confidentiality

Ethics approval

University ethics approval to conduct the current research was granted by the QUT Human Research Ethics Committee (Approval Number: 1000000047). An ethics application was submitted in January 2010 through the National Ethics Application Form (NEAF) to the Human Research Ethics Committee at QUT. There was some initial difficulty in obtaining ethics approval because of the risk that participants would disclose unrelated indictable offences to the researcher during the course of the interview. This concern was related to section 133 of the Criminal Code (Qld) which states that it is an offence for a person to receive a benefit in return for not disclosing an indictable offence to the police. There was concern that in the research environment there is a risk that an interviewee's participation in the research could be of benefit to the researcher, and therefore encourage the researcher to not report knowledge of an indictable offence disclosed during interview. While the use of illicit drugs constitutes a summary offence, the disclosure of a more serious indictable offence to the researcher during an interview could constitute an offence to the researcher. There is also a risk that investigation of specific offences or individuals may result in the issue of a warrant or subpoena with the result that the researcher would be legally compelled to provide information of an interviewee to law enforcement agencies, or risk prosecution. To safeguard against this risk the ethics committee stipulated that legal advice be obtained prior to ethics approval being granted.

Confidentiality and risk

Following legal advice, the Ethics Committee and the researcher agreed to some strategies that could help safeguard against the risk of interviewees disclosing an indictable offence during an interview. Ethics approval was made conditional upon the researcher recruiting participants in such a way as to ensure their complete anonymity. Pseudonyms were subsequently used for all participants who used drugs, and the researcher obtained informants' verbal, recorded consent, rather than written

consent which could identify the individual. All informants who used drugs were provided with a participant information sheet containing a description of the research and information about their participation, including the risk of disclosing any indictable offences during the interview. A further verbal reminder was issued to drug user participants at the beginning of the interview (see Appendix D and Appendix E). Participation in the research was voluntary and all respondents were informed that they did not have to answer any questions they do not wish to respond to, and could stop the interview at any time.

The Participant Information Sheet for service providers and other professionals included a consent form requiring the interviewees' signature prior to interview (see Appendix C). While some drug service providers and other professionals were willing to allow their names to be used in the thesis, it was decided for confidentiality purposes, to use pseudonyms for all respondents involved in the governance of drugs. The names of their organizations were not recorded during interview and are not mentioned in this thesis.

Appendix B: Stakeholder information sheet and consent form

PARTICIPANT INFORMATION for QUT RESEARCH PROJECT

Governing drug use among young people:
Crime, harm and contemporary drug use practices

Consent form for stakeholders

Research Team Contacts	
Margaret Pereira PhD student School of Justice Phone: 0418 871 192 Email: m.pereira@qut.edu.au	Professor Kerry Carrington School of Justice Phone: 3138 7112 Email: kerry.carrington@qut.edu.au

Description

This project is being undertaken as part of a PhD project for Margaret Pereira from the QUT School of Justice and will form the basis of her PhD at The Queensland University of Technology under the supervision of Professor Kerry Carrington, School of Justice.

The purpose of this project is twofold. Firstly the project aims to explore how drug use is managed for young people aged between 18-25 years. Secondly the project aims to understand how young people use drugs and how this may be impacted by factors such as policing and beliefs about harms associated with drug use.

Illicit drug use has traditionally been associated with legal, social or psychological problems. In recent years it has become evident that there are many different types of illicit drug users who use a diverse range of drugs for a variety of reasons. While it is certainly true that illicit drugs can cause harm for the drug user and for the community, there are in fact many other reasons why young people use drugs such as leisure and relaxation.

The research team regards the experiences of key professionals and service providers as valuable, and therefore we would like to you to be included in the research. The research does not propose a model of drug policy, but rather, seeks to provide a knowledge base for possible future policy development.

Participation

Your participation in this project is voluntary. If you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty. Your decision to participate will in no way impact upon your current or future relationship with QUT or with the researchers.

The study involves participating in an informal interview which will take around 30 to 60 minutes of your time. Confidentiality in all responses will be assured and a pseudonym will

be used unless you prefer to be recorded by your own identity. Responses will be written and recorded, if agreed to by you, to ensure accuracy. You will be asked questions about your role as a medical professional, or drug law enforcement officer, or drug service provider. You will also be asked if current drug policies impact on the work you do, and you will be invited to discuss your experiences with people who use illicit drugs.

You may stop the interview at any time, and if you do not wish to continue the audio recording will be erased, written data will be destroyed, and the information provided will not be included in the study. Your participation in this project is voluntary. If you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty. Your decision to participate will in no way impact upon your current or future relationship with QUT.

Expected benefits

It is expected that this project will not directly benefit you. However, the research will yield new knowledge for the benefit of further research into developing effective drug policies to address problems of harmful illicit drug use.

Risks

It is expected that there are no risks beyond normal day-to-day living associated with your participation in this project. **It is a requirement of the research that children are not present during interviewing.**

Confidentiality

All comments and responses are anonymous and will be treated confidentially. The names of individual persons are not required in any of the responses unless you prefer that your name be included. All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Audio tape or another audio recording device will be used to record interviews and conversations. If you do not agree to be recorded in this way, interviews will be transcribed by means of writing or a laptop computer. All interviews will be conducted face to face. The recordings will only be used for the purposes of transcribing interviews to ensure accuracy of written record. No names or any identifying information will be recorded. Comments made by you during the interview will be verified at the end of the interview. However you will not be contacted again for further verification prior to the final inclusion of your data in the project.

All materials collected during the study including files, tapes and questionnaires will be de-identified and kept locked in a secure filing cabinet at the QUT School of Justice for the duration of the research. No names or addresses or any individually identifying data will be recorded during interviews. Participant anonymity will be guaranteed. Transcribed interview records will code the respondents by number, not name. Transcripts of interviews stored on computer files will be protected by means of a password. Upon completion of the research all interview materials will remain in a secure, locked filing cabinet in the School of Justice, QUT.

All comments and responses are anonymous and will be treated confidentially. The names of individual persons are not required in any of the responses.

Consent to Participate

We would like to ask you to sign a written consent form (enclosed) to confirm your agreement to participate.

Questions / further information about the project

Please contact the researcher team members named above to have any questions answered or if you require further information about the project.

Concerns / complaints regarding the conduct of the project

QUT is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the QUT Research Ethics Officer on +61 7 3138 5123 or ethicscontact@qut.edu.au. The Research Ethics Officer is not connected with the research project and can facilitate a resolution to your concern in an impartial manner.

QUT	CONSENT FORM for QUT RESEARCH PROJECT
Research Team Contacts	
Professor Kerry Carrington – Head of School of Justice 3138 7112 kerry.carrington@qut.edu.au	Margaret Pereira 0418871192 m.pereira@qut.edu.au
Governing drug use among young people : Crime, harm and contemporary drug use practices	

Statement of consent

By signing below, you are indicating that you:

- have read and understood the information document regarding this project
- have had any questions answered to your satisfaction
- understand that if you have any additional questions you can contact the research team
- understand that you are free to withdraw at any time, without comment or penalty
- understand that you can contact the Research Ethics Officer on +61 7 3138 5123 or ethicscontact@qut.edu.au if you have concerns about the ethical conduct of the project
- agree to participate in the project
- understand that the project will include audio recording

Name .....

Signature .....

Date ..... / ..... / .....

Media Release Promotions

From time to time, we may like to promote our research to the general public through, for example, newspaper articles. Would you be willing to be contacted by QUT Media and Communications for possible inclusion in such stories? By ticking this box, it only means you are choosing to be contacted – you can still decide at the time not to be involved in any promotions.

☐ **Yes, you may contact me about inclusion in promotions**

☐ **No, I do not wish to be contacted about inclusion in promotions**

WITHDRAWAL OF CONSENT FORM FOR QUT RESEARCH PROJECT

Governing drug use among young people: Crime, harm and contemporary drug use practices

Research Team Contacts	
Professor Kerry Carrington – Head of School of Justice	Margaret Pereira
3138 7112	0418871192
kerry.carrington@qut.edu.au	m.pereira@qut.edu.au

I hereby wish to WITHDRAW my consent to participate in the research project named above.

I understand that this withdrawal WILL NOT jeopardise my relationship with Queensland University of Technology.

Name .....

Signature .....

Date ..... / ..... / .....

Appendix C: Stakeholder Interview Schedule

Interview Schedule for Stakeholders

1. Can you describe your role/responsibilities in managing illicit drug use?

2. How is your work aligned with current drug policies?

3. Can you tell me about some of the drug users aged 18-25 years you have contact with or who access your services?

4. What sorts of drugs do they use?

5. Do you regard their drug use as problematic and why/why not?

6. What is your understanding of drug related harm? Does this apply to all/most/few types of drug use?

7. Do you regard your professional role/responsibilities as important to reducing drug related harm? Why/why not?

8. From your experience how much contact do drug users have with the criminal justice system and do you believe this is necessary and helpful? Why/why not?

9. Do you think illicit drug use amongst the 18-25 year age group has a negative impact on the community? Why/why not?

10. Do you experience any professional difficulties, frustrations or barriers in dealing with the problems associated with illicit drug use? Is this due to a policy issue or an administrative/bureaucratic issue?

11. Do you feel as if current drugs policies are working well to reduce harmful illicit drug use? Why/why not?

12. In your opinion, what are the main weaknesses and strengths of current drug policies? Is there room for improvement?

Appendix D: Drug user participant information sheet

PARTICIPANT INFORMATION for QUT RESEARCH PROJECT

Governing drug use among young people:
Crime, harm and contemporary drug use practices

Participant Information Sheet for drug users

Questions / further information about the project

Please contact the researcher team members named above to have any questions answered or if you require further information about the project.

Research Team Contacts	
Margaret Pereira PhD student School of Justice Phone: 0418 871 192 Email: m.pereira@qut.edu.au	Professor Kerry Carrington School of Justice Phone: 3138 7112 Email: kerry.carrington@qut.edu.au

Description

This project is being undertaken as part of a PhD project for Margaret Pereira from the QUT School of Justice and will form the basis of her PhD at The Queensland University of Technology under the supervision of Professor Kerry Carrington, School of Justice.

The purpose of this project is twofold. Firstly the project aims to explore how drug use is managed for young people aged between 18-25 years. Secondly the project aims to understand how young people use drugs and how this may be impacted by factors such as policing and beliefs about harms associated with drug use.

Illicit drug use has traditionally been associated with legal, social or psychological problems. In recent years it has become evident that there are many different types of illicit drug users who use a diverse range of drugs for a variety of reasons. While it is certainly true that illicit drugs can cause harm for the drug user and for the community, there are in fact many other reasons why young people use drugs such as leisure and relaxation.

Participation

Your participation in this project is voluntary. If you do agree to participate, you can withdraw from participation at any time during the project without comment or penalty. Your decision to participate will in no way impact upon your current or future relationship with QUT or with the researchers. **It is a requirement of the research that children are not present during interviewing.**

The study involves participating in an informal interview which will take around 30 to 60 minutes of your time. You will be invited from the initial point of contact to use an alias. You will not be referred to by your real name during recorded interviews and interview transcripts will be recorded with a pseudonym. Responses will be written and recorded, if agreed to by you, to ensure accuracy. You will be asked questions about drug use, your lifestyle and your demographic background for responses and comparative data.

You may stop the interview at any time if you do not wish to continue, the audio recording will be erased, written data will be destroyed, and the information provided will not be included in the study. As all material will be anonymous and non-identifiable withdrawal from the project will not be possible once the data analysis has begun.

Expected benefits

It is expected that this project will not directly benefit you. However, the research will yield new knowledge for the benefit of building a better understanding of illicit drug use and people who use illicit drugs.

Risks

Although psychological distress is highly unlikely, if you should become distressed, the interview will be stopped and you will be offered follow up counseling. QUT provides for limited free counselling for research participants of QUT projects, who may experience discomfort or distress as a result of their participation in the research. Should you wish to access this service please contact the Clinic Receptionist of the QUT Psychology Clinic on 3138 0999. Please indicate to the receptionist that you are a research participant. Alternatively you can contact the Lifeline 24 hour Crisis Counselling line on 13 11 14 or Kids Helpline for young people aged to 25 years on 1800 55 1800.

There is a risk that I may be compelled to disclose information to relevant authorities about indictable offences revealed to me in the interview. As a researcher it is my duty to avoid knowledge of such offences as disclosure of these activities could compromise confidentiality and place the researcher and the interviewee at risk of prosecution through participation in the research project. To avoid risk of disclosure of indictable offences your identity will remain anonymous and you will be asked at the beginning of the interview not to disclose details of any such offence for which you have not been previously apprehended, charged or convicted. If you begin to disclose any such details to the interviewer, the interview will be stopped.

Confidentiality

All comments and responses are anonymous and will be treated confidentially. The names of individual persons are not required in any of the responses. Subject to the legal issues described above, all aspects of the study, including results, will be strictly confidential and details of your identity as a participant will not be recorded. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

An audio recording device will be used to record interviews and conversations. If you do not agree to be recorded in this way, interviews will be transcribed by means of writing or a laptop computer. All interviews will be conducted face to face. The recordings will only be used for the purposes of transcribing interviews to ensure accuracy of written record. No names or any identifying information will be recorded. Comments made by you during the interview will be verified at the end of the interview. However you will not be contacted again for further verification prior to the final inclusion of your data in the project.

All materials collected during the study including files, tapes and questionnaires will be de-identified and kept locked in a secure filing cabinet at the QUT School of Justice for the duration of the research. No names or addresses or any individually identifying data will be recorded during interviews. Participant anonymity will be guaranteed. Transcribed interview records will code the respondents by number, not name. Transcripts of interviews stored on computer files will be protected by means of a password. Upon completion of the research all interview materials will remain in a secure, locked filing cabinet in the School of Justice, QUT.

All comments and responses are anonymous and will be treated confidentially. The names of individual persons are not required in any of the responses.

Consent to Participate

To ensure complete anonymity a verbal consent mechanism will be used. I will confirm your consent at the commencement of interview, ensuring you have understood this information sheet. This verbal consent will be recorded within the interview transcript.

Concerns / complaints regarding the conduct of the project

QUT is committed to researcher integrity and the ethical conduct of research projects. However, if you do have any concerns or complaints about the ethical conduct of the project you may contact the QUT Research Ethics Officer on +61 7 3138 5123 or ethicscontact@qut.edu.au. The Research Ethics Officer is not connected with the research project and can facilitate a resolution to your concern in an impartial manner.

Appendix E: Drug user Interview Schedule

Interview Schedule for Drug Users

Verbal Caution

Before we begin this interview I need to inform you that the information you provide in this interview will remain confidential and will not be disclosed to anyone, except where there is an obligation at law to do so.

I may be required or compelled to disclose information obtained in the interview, including the details of any indictable offence disclosed in the interview for which you have not been previously apprehended, charged or convicted and/or any details of any actual or perceived risk of harm or injury to you (including self-harm) or any third person.

As a researcher it is my duty to avoid knowledge of such offences, as disclosure of these activities could compromise confidentiality and place the researcher and the interviewee at risk of prosecution. I will stop the interview and caution you regarding the legal position if you begin to disclose details of any criminal offence for which you have not been previously apprehended, charged or convicted. I would also like to remind you that you can withdraw your consent to participate in the research at any time before or during the interview.

Do you understand the risks and consent to this interview?

1. What sorts of drugs do you use, how do you use them and how often? (eg. use alone/with friends/only at parties)

2. Why do you use drugs eg. pleasure/peer pressure?

3. How would you describe your drug use eg. a bit of fun/recreational/time out/habitual/an addiction etc? Explain.

4. Does your drug use ever impact on other areas of your life such as study/employment/ housing/relationships/health? Is this a problem?

5. How long have you been using drugs and why did you start using drugs?

6. Do you think your drug use is harmful to you, your friends/family or the community? Why/why not?

7. Are other types of drug use less/more harmful? How?

8. Can you tell me what sorts of effects you get from the drugs you use? Can you also describe how you feel when you use drugs and tell me what the best and worst aspects of your drug use are?

9. Are you concerned about getting a drug conviction, becoming addicted to drugs, or suffering physical/psychological/mental injury from your drug use?

10. Does the fear of harm ever prevent you from using drugs? Why/why not?

11. Have you ever had contact with the criminal justice system because of your drug use? What happened? Did this impact on your drug use eg. deter you from using drugs?

12. Do you family/friends know about your drug use and if so, are they concerned?

13. Do you intend to continue your drug use in the future? Please describe how you imagine a future with/without drugs.

14. Have you ever accessed drug treatment services or drug rehabilitation? Was this helpful?

15. Is it good that drugs are illegal? Which drugs should/should not be illegal and why/why not? Would you use drugs differently if they were legal?